

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	

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 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** Based on policy review, medical record review, observation, and interview, the facility failed to implement interventions on the care plan for 1 of 5 (Resident #25) sampled residents reviewed for Hydration and Nutrition. The findings include: 1. Review of the undated facility policy titled Using the Care Plan, revealed .It is the policy of the facility that the care plan be used in developing the resident's daily care routines.Daily care and documentation should be consistent with the resident's care plan . 2. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Dysphagia, Need for Assistance with Personal Care, Diabetes, Abnormal Weight Loss, and Congestive Heart Failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment and required total assistance with eating. Review of the care plan revised 6/10/2025, revealed .I am at risk for DEHYDRATION / FLUID IMBALANCE.Ensure that I have access to cool, fresh drinking water at bedside whenever possible dated 11/14/2023.I am at risk for alteration in NUTRITIONAL status.Add snack at 10 am [10:00 am] and 2pm [2:00 pm] related to continued weight loss.Revision on: 12/12/2024.I am at risk for impairment to SKIN INTEGRITY including.need for hands on assist with eating. I have an ADL [activities of daily living] self-care performance deficit / FUNCTIONAL MOBILITY LIMITATION r/t [related to] weakness. Eating: Partial/Moderate Assistance - Up to dependent assistance. Observation in Resident #25's room on 8/11/2025 at 9:40 AM, 10:56 AM, 12:42 PM, and 3:02 PM, revealed Resident #25 was in bed and the water pitcher was on the over the bed table out of reach. Observation in Resident #25's room on 8/11/2025 at 12:58 PM revealed Certified Nursing Assistant (CNA) A entered the room, provided tray set up, encouraged Resident #25 to eat then left the room. CNA A did not stay in the room and provide additional encouragement or assistance if needed during the meal. During an interview and observation in the resident's room on 8/11/2025 at 4:05 PM, the Director of Nursing (DON) confirmed that Resident #25 should have fresh water available, and the water pitcher should be in the resident's reach. Observation in Resident #25's room on 8/12/2025 at 7:42 AM, revealed Resident #25 was observed attempting to eat breakfast, without staff in the room to assist. During an interview on 8/12/2025 at 10:12 AM, Licensed Practical Nurse (LPN) B confirmed Resident #25 had orders for snacks to be provided at 10:00 AM and 2:00 PM, and that the resident had not received a snack. During an interview on 8/12/2025 at 3:31 PM, the DON confirmed Resident #25 should have been receiving a snack and staff should follow the plan of care.</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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to conduct a care plan conference with the family representative for 1 of 7 (Resident #8) sampled residents reviewed. The findings include: The facility policy titled, Resident/Family Participation, dated 12/12/2017, revealed .It is the policy of this facility that each resident and his-her family members be encouraged to participate in the development of the resident's comprehensive assessment and care plan .Resident's representative are invited to attend and participate in the resident's assessment and care planning conference . Review of medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Dementia, Diabetes, Hypertension, and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Statue (BIMS) score of 4, which indicated Resident #8 was severely cognitively impaired. Review of the Care Plan revision dated 7/8/2025, revealed .Resident #8 had a BIMs of 5, that indicated severe cognitive impairment . During a phone interview with Resident #8's grandson on 8/11/2025 at 11:19 AM, Resident #8's grandson stated that he had never been invited to a care plan meeting. During an interview on 08/13/2025 at 8:30 AM, the Social Service Director (SSD) stated, Resident #8 is his own Responsible Party, and he was invited to the care plan meetings. The SSD was asked if Resident #8's BIMs score was a 5. The SSD stated, Yes. During an interview on 8/13/2025 at 9:29 AM, the Director of Nursing (DON) was asked who should be invited to a care plan meeting. The DON stated the resident and their representative. The DON was asked if a resident has a BIMS score of 5, should they be their own responsible party. The DON stated, No. The DON was asked if a resident has a BIMS score of 5 should they be the only party invited to the care plan meeting or should family member be invited too. The DON stated, No, the family should be invited also.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**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 care and services to assess, treat and prevent the spread of infection for 1 of 2 (Resident #36) sampled residents reviewed for pressure ulcers. The findings include: 1. Review of the facility policy titled, Handwashing/Hand Hygiene, revised June 2010 .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.Resident, family members and/or visitors will be encouraged to practice hand hygiene.Employees must wash their hands for at least fifteen (15) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions.Before and after changing a dressing.If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations.before and after direct contact with residents.Before handling clean or soiled dressings, gauze pads, etc.After handling used dressings, contaminated equipment, etc.After removing gloves.The use of gloves does not replace handwashing/hand hygiene. Review of the facility policy titled, Skin Care Process, dated January 17, 2018 .It is the policy of this facility to provide care and services with the goal of maintaining the resident's skin integrity and to provide care and services that meet professional standards to treat the loss of skin integrity should it occur.Staff education related to skin care process.Nursing staff should receive training regarding skin and skin care as appropriate upon hire and periodically thereafter.Nurses may need further training in evaluation, assessment, staging and measuring wounds prior to being responsible for wound care.American Medical Technologies provides education materials and guidance.Registered Nurse.Observes wounds weekly. May be responsible for measuring and documenting the progress of the wound.Documentation should include, but is not limited to, regular skin inspections, pressure wound measurements and progress, turning and repositioning, the use of special products or equipment.When documenting, it is important to include the location of the wound, presence of exudate, pain, signs of infections, and the wound bed characteristics.Nurses are encouraged to document descriptions of their observations if in doubt about the specifics of a wound such as the staging a pressure ulcer would or etiology of a wound. 2. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnosis including Dementia, Chronic Obstructive Pulmonary Disease (COPD), Muscle Weakness, Pressure Ulcer, and Obesity. Review of quarterly [NAME] Data Set (MDS) dated [DATE], revealed Resident #36 was severely cognitively impaired, was dependent with all Activities of Daily Living (ADLs) and had no pressure ulcers/injuries. Review of the Progress Note dated 6/29/2025 at 12:15 PM, revealed .[Resident #36] has a stage II ulcer to inside of right foot . Review of the Weekly Pressure Injury Record - V 2, dated 6/29/2025, 7/6/2025, 7/13/2025, 7/20/2025 and 7/27/2025, revealed .Wound Origin . Facility acquired .Date first observed 6/29/2025 .Wound location: right inside foot on ankle .Pressure injury stage .[marked as] c. Stage 2 - Partial Thickness loss of dermis presenting as a shallow ulcer with a red pink wound bed, without slough .Wound Bed [marked as] 1. Normal for skin .Surrounding Skin Color [marked as] 1. Normal for skin .Surrounding Tissue/Wound Edge [marked as] 1. Normal for Skin . Review of the Physician's orders dated 7/1/2025, revealed .Wound care to the right medial ankle [the inner side of the right ankle joint] .Alginate calcium with silver [a wound dressing composed of calcium alginate and silver particles designed to promote healing in wounds], silver sulfadiazine [a topical antibiotic cream used to prevent and treat wound infection], ABD pad [absorbent dressing used for wound care], and wrap with gauze roll, (kerlix) once daily or PRN [as needed] if dressing becomes soiled or dislodged one time a day for Wound Care related to PRESSURE ULCER . STAGE 2. Review of the (Named Company) SPECIALTY PHYSICIAN WOUND & [and] MANAGEMENT SUMMARY, dated 7/10/2025, 7/15/2025, 7/17/2025, 7/22/2025, 7/24/2025, revealed .UNSTAGEABLE DTI [Deep Tissue Injury] OF THE RIGHT ANKLE UNDETERMINED THICKNESS .Skin .Intact with purple/maroon discoloration . Review of the quarterly MDS dated [DATE], revealed Resident #36 was severely cognitively impaired, was dependent with all ADLs, and had an unhealed pressure ulcer, unstageable, presenting as a deep tissue injury. Review of the (Named Company) SPECIALTY PHYSICIAN WOUND & [and] MANAGEMENT SUMMARY dated 7/29/2025, 7/31/2025, and 8/5/2025, revealed STAGE 3 PRESSURE WOUND OF THE RIGHT ANKLE FULL THICKNESS .Slough [dead tissue] .75% [percent] . Review of the Weekly Pressure Injury Record-V 2 dated 8/3/2025, revealed Resident #36 obtained a facility acquired pressure ulcer that was identified on 6/29/2025 .The wound was on</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**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 an environment free of accident hazards when nursing staff left a razor open and unattended on a bedside table for 1 of 35 (Resident #2) residents reviewed. The findings include: 1. Review of the facility policy titled, Sharps Disposal dated 8/2009, revealed .This facility shall discard contaminated sharps into designated containers. Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers. 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnosis including Cerebral Infarction (a condition where brain tissue dies due to lack of blood supply), Post-Traumatic Stress Disorder, Anxiety, Diabetes, Depression, and Seizures. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated that Resident #2 was cognitively intact and was dependent with personal hygiene including shaving. Review of the care plan dated 7/25/2025, revealed .I have an ADL [Activities of Daily Limit] self-care performance deficit .I will receive adequate level of assistance with daily care tasks through next review date .Personal Hygiene.Dependent .I am at risk for BEHAVIORS r/t [related to] hx [history] of using forks to scratch my skin causing skin compromise .I have a hx of using objects other than my fingernails to scratch myself . Observation in Resident #2's room on 8/11/2025 at 4:12 PM, revealed an open and unattended razor lying on a bedside table positioned beside Resident #2's bed. During an observation and interview in Resident #2's room on 8/11/2025 at 4:17 PM, Licensed Practical Nurse (LPN) E confirmed that an open and unattended razor should not be at Resident #2's bedside. During an interview on 8/13/2025 at 12:37 PM, the Director of Nursing (DON) confirmed that razors should not be left open and unattended.</p>

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>Based on facility policy review, Centers for Medicare and Medicaid (CMS) Payroll-Based Journal (PBJ) Staffing Data Report, employee timesheet review, and interview the facility failed to ensure sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident during the 2nd quarter (1/1/2025-3/31/2025) for 8 of 26 days reviewed. The facility census upon entrance was 35. The findings include: 1. Review of the facility policy titled, Staffing, dated 10/2017, revealed .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment.Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services.Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care. 2. Review of the CMS 2nd Quarter 2025 PBJ Staffing Data Report for the facility revealed a concern for low weekend staffing and a 1star staffing rating. 3. Review of the employee time sheets dated 1/11/2025, revealed 33.68 total staffing hours for Certified Nursing Assistants (CNAs), 22.54 for Licensed Practical Nurses (LPNs), and 0 for Registered Nurses (RNs) with a census of 32. The Per Patient Day (PPD- refers to nursing hours allocated to each resident per day) was 1.76. The facility failed to provide 24 hours of nursing on 1/11/2025. Review of the employee time sheets dated 1/25/2025, revealed 40.6 total staffing hours for CNAs, 0 for LPNs, and 11.87 for RNs with a census of 32. The PPD was 1.64. The facility failed to provide 24 hours of nursing on 1/25/2025. Review of the employee time sheets dated 1/26/2025, revealed the total staffing hours of 53.74 for CNAs, 0 for LPNs, and 11.67 for RNs with a census of 32. The facility failed to provide 24 hours of nursing on 1/26/2025. Review of the employee time sheets dated 3/1/2025, revealed 4 total staffing hours for CNAs, 0 for LPNs, and 11.93 for RNs with a census of 32. The PPD was 0.5. The facility failed to provide 24 hours of nursing on 3/1/2025. Review of the employee time sheets dated 3/2/2025, revealed 42.4 total staffing hours for CNAs, 0 for LPNs, and 13.12 for RNs with a census of 32. The PPD was 1.74. The facility failed to provide 24 hours of nursing on 3/2/2025. Review of the employee time sheets dated 3/22/2025, revealed 42.4 total staffing hours for CNAs, 5 for LPNs, and 0 for RNs with a census of 39. The PPD was 1.22. The facility failed to provide 24 hours of nursing on 3/22/2025. Review of the employee time sheets dated 3/23/2025, revealed 56.35 total staffing hours for CNAs, 16 for LPNs, and 0 for RNs with a census of 38. The PPD was 1.9. The facility failed to provide 24 hours of nursing on 3/23/2025. Review of the employee time sheets dated 3/30/2025, revealed 56.79 total staffing hours for CNAs, 15.87 for LPNs, and 0 for RNs with a census of 36. The facility failed to provide 24 hours of nursing on 3/30/2025. The facility was unable to provide additional printed off employee time sheets for 1/11/2025, 1/25/2025, 1/26/2025, 3/1/2025, 3/2/2025, 3/22/2025, 3/23/2025, and 3/30/2025 as requested. 4. During an interview on 8/14/2025 at 10:11 AM the Director of Nursing (DON) confirmed there should always be a nurse in the facility.</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, employee timesheets, and interview, the facility failed to provide sufficient nursing staff with appropriate competencies and skill sets to ensure residents attain or maintain the highest level of practicable physical well-being when the facility failed to ensure that a Cardiopulmonary Resuscitation (CPR) certified staff member was working 24 hours per day for 16 of 40 days reviewed. The facility had a census of 35 upon entrance. The findings include: 1. Review of the policy titled, Staffing, dated 10/2017, revealed .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. 2. Review of the employee timesheets dated [DATE]-[DATE], [DATE]-[DATE], [DATE]-[DATE], [DATE]-[DATE], [DATE]-[DATE], and [DATE]-[DATE], revealed there was not a CPR certified staff member working in the facility for 24 hours for the dates as follows: a. [DATE] b. [DATE] c. [DATE] d. [DATE] e. [DATE] f. [DATE] g. [DATE] h. [DATE] i. [DATE] j. [DATE] Review of the employee timesheets dated [DATE]-[DATE], revealed there was not a CPR certified staff member working in the facility for 24 hours for the dates as follows: a. [DATE] b. [DATE] c. [DATE] d. [DATE] e. [DATE] f. [DATE] Review of the Resident Status List dated [DATE]-[DATE] revealed 30 of 52 residents listed with Full Code status. 3. During an interview on [DATE] at 10:11 AM, the Director of Nursing (DON) confirmed there should be a CPR certified staff member in the facility at all times during each 24-hour day.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>Based on daily staffing sheet review, observation, and interview, the facility failed to post daily staffing sheets that included the number of actual hours worked by each discipline for 31 of 31 days. The findings include: Review of the facility's posted daily staffing sheets dated 7/12/2025-8/11/2025, revealed the actual number of hours worked by Registered Nurses (RN), Licensed Practical Nurses (LPN), and Certified Nursing Assistants (CNA) was not included. Observations in the facility's front entrance lobby on 8/11/2025 at 10:30 AM, 8/12/2025 at 7:30 AM, and 8/13/2025 at 7:30 AM, revealed the posted daily staffing sheet did not include the actual number of hours worked by the RN, LPN, and CNA. During an interview on 8/13/2025 at 5:43 PM, the Director of Nursing (DON) confirmed the posted daily staffing sheet should include the actual number of hours worked by the RN, LPN, and CNA. Observation in the facility's front entrance lobby on 8/14/2025 at 7:30 AM, revealed the posted daily staffing sheet did not include the actual number of hours worked by the RN, LPN, and CNA.</p>

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on policy review, Pharmacy Executive Summary review, observation, and interview, the facility failed to ensure medications were properly stored and secured when refrigerated medications were stored outside of the recommended temperature range for 1 of 1 medication refrigerator observed, when 2 nurses (Licensed Practical Nurse (LPN) A and LPN E) left medications unattended in 1 of 1 medication room, and when one of two (B Hall Medication Cart) medication carts was left unsecured and unattended. The findings include: 1. Review of the facility policy titled, Medication Labeling and Storage, revised 2/2023, revealed .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others. Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. Review of the (Named Pharmacy) Executive Summary Comments form dated 5/29/2025, revealed .Refrigerated Medications should be between 36 degrees and 46 degrees. Observation in the A/B Hall Medication Room on 8/12/2025 beginning at 3:11 PM, revealed LPN A unlocked the medication room, left the door open, and walked away leaving the surveyor alone and medications in the medication room out of sight of staff for 9 minutes. The medication refrigerator was 65 degrees Fahrenheit (F), and the door was ajar due to ice buildup in freezer section preventing the door from closing. Water was noted in the refrigerator, on the floor and on the medications contained in the refrigerator. The medication refrigerator contained the following medications: a. a box of five 3 milliliter (ml) Lantus (a medication used to treat Diabetes) 100 unit (a basic measurement for an amount of insulin)/ml pens. b. a box of five 3 ml Insulin Lispro (a medication used to treat Diabetes) 100unit/ml pens, six 3ml Lantus 100 unit/ml pens, one 10 ml bottle of Insulin Lispro 100 unit/ml. c. an opened bottle of Tuberculin (a combination of proteins used to diagnose tuberculosis) Serum. d. an emergency supply box containing one 10 ml vial of Novolog 70/30 (a medication used to treat Diabetes), one 10 ml vial of Novolin N (a medication used to treat Diabetes), one 10 ml vial of Novolin R (a medication used to treat Diabetes) and, four Promethazine [a medication used to treat nausea and vomiting] 25 milligram (mg) suppository. Review of the Medication Refrigerator Temperature Log for 5/2025, revealed no temperature was logged on the following days: 5/1/2025-5/5/2025, 5/7/2025-5/8/2025, 5/15/2025-5/18/2025, 5/28/2025-5/29/2025. Review of the Medication Refrigerator Temperature Log for 6/2025, revealed no temperature was logged on the following days: 6/1/2025-6/6/2025, 6/9/2025-6/10/2025, 6/13/2025-6/30/2025. Review of the Medication Refrigerator Temperature Log for 7/2025, revealed no temperature on the following days: 7/20/2025 and 7/22/2025-7/31/2025. Review of the Medication Refrigerator Temperature Log for 8/2025, revealed no temperature on 8/11/2025 and 8/12/2025. During an observation and interview in the A/B Hall Medication Room on 8/12/2025 at 3:20 PM, the Regional Consultant confirmed that the medications contained in the medication refrigerator were stored at an incorrect temperature and were no longer safe for use. Observation in the A/B Hall Medication Room on 08/13/2025 at 10:13 AM, revealed LPN E unlocked the door to the medication room, left the door open, and exited leaving the surveyor alone and medications in the medication room out of sight of staff for 6 minutes. The medication refrigerator showed a temperature of 32 degrees F and the freezer area showed a temperature of 30 degrees. During an interview on 8/13/2025 at 2:38 PM, the Director of Nursing (DON) confirmed that storing medications outside of the manufacturers recommended temperature range could alter the medications effectiveness, that the medication refrigerator's temperature should be checked daily and maintained in a log book, that the temperature should be maintained between 36 degrees F and 46 degrees F, that the medication refrigerator's log book was inconsistent and incomplete for the months of May, June, July, and August 2025, and that no one should be in the medication room without licensed nursing staff present. Observation at the nurse's station on 8/14/2025 at 11:25 AM, revealed the B Hall medication cart was unlocked, unattended, and parked beside the nurses' station. During an interview on 8/14/2025 at 11:27 AM, LPN I was asked if the medication cart was unlocked. LPN I confirmed the cart was unlocked and should have been locked.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445354	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2025
NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	
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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>Based on policy review, observation, and interview, the facility failed to provide sufficient staff with the competencies and skill sets to carry out the functions of the food and nutrition services when there was not a Dietary Manager employed in the kitchen. The facility had a census of 35 with 35 of those residents receiving a meal tray from the kitchen. The findings include: Review of the facility policy titled, Staffing, with a revision date of 10/22, revealed .Other support services (.dietary, activities/recreational.staff to ensure resident needs are met. Observations in the Kitchen on 8/11/2025 at 9:15 AM, 8/12/2025 at 10:30 AM, and 8/13/2025 at 2:10PM, revealed the kitchen had no standard cleaning schedules, this was evident by large plastic containers holding dry food items with dried substances and loose particles on top of the lids and down sides of containers; when stainless steel tables, metal storage racks, and the steam table shelf, were found with dried, splattered substances on their surfaces, the walk in dry storage area had a dried white powdery substance on the floor and on top of 2 brown boxes located on a shelf. The outside of the ICE machine had dried liquid spills running down the front and sides. The Inside of the ICE machine has several white streaks running down the inside walls around the door area. During an interview on 8/11/2025 at 9:15 AM, the Registered Dietitian (RD) confirmed that the Dietary Department currently did not have a Dietary Manager. The RD stated, She didn't know how to do her job, she only ordered food supplies one day a week and it was never enough. During an interview on 8/13/2025 at 10:45AM, the RD confirmed that the facility did not have a 3-day emergency supply of food. The RD stated, [The] Dietary Manager would run out of food and pull things from the 3-day emergency supply. During an Interview on 8/13/2025 at 2:10 PM, the Administrator confirmed that the Dietary Manager had been let go on Friday 8/8/2025, due to lack of competencies and skill sets to carry out the functions of Dietary Manager.</p>		

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NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	
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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>Based on facility menu review, observation, and interview, the facility failed to serve food items from the menu posted for 3 out of 3 days reviewed during the recertification survey. The census was 35 with 35 residents receiving meals. The findings include: Review of the facility lunch menu dated 8/11/2025, revealed Beef Ravioli with sauce, seasoned green beans, bread/roll, butter/margarine, and frosted cake. The menu was changed by the Registered Dietitian at 9:15 AM on 8/11/2025, due to lack of food items needed to fill the posted menus for 8/11/2025, 8/12/2025, and 8/13/2025. Observation of the lunch menu on 8/11/2025, revealed meat loaf, sweet potatoes, sugar snap peas, bread/roll, butter/margarine, and frosted white cake. Review of the facility lunch menu dated 8/12/2025, revealed pork riblet with barbeque (BBQ) sauce, savory green rice, seasoned succotash, and creamy raspberry dessert. Observation of the lunch menu on 8/12/2025, revealed roast pork, savory white rice, black eyed peas, bread/roll, butter/margarine, and blue berry dessert. Review of the facility lunch menu dated 8/13/2025, revealed cornmeal crusted chicken, mashed sweet potatoes, sugar snap peas, bread/roll, butter/margarine, and pudding parfait. Observation of the lunch menu on 8/13/2025, revealed the sugar snap peas were substituted with greens. Review of the facility lunch menu dated 8/13/2025, revealed shrimp and smoked sausage sheet pan roast, fried zucchini, corn scone with butter/margarine, and Banana spice cake. Observation of the lunch menu on 8/13/2025, revealed pulled pork, French fries, baked beans, with hamburger as the alternate. During an interview on 8/11/2025 at 9:28 AM, the Registered Dietitian (RD) confirmed that some of the food items needed to complete the menu for the week of 8/10/2028 - 8/16/2025 were not in inventory. The RD confirmed what is posted on the menu is what should be served that day to meet the nutritional needs of the residents.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions, when large plastic containers holding dry food items revealed dried substances and loose particles on top of the lids and down the sides of the containers; when stainless steel tables, metal storage racks, and the steam table shelf, were found with dried, splattered substances on their surfaces; and when the walk in dry storage area had a dried white powdery substance on the floor and on top of 2 brown boxes located on a shelf. The outside of the ICE machine contained dried liquid spills down the front and both sides and the inside of the ICE machine contained several white streaks running down the inside walls around the door area. Clean dishes were stored in an area where dirty dishes were being washed. The side-by-side refrigerator contained four opened liquid containers with no open date on the containers. The Facility failed to maintain a complete, 3-day emergency supply of food. Cleaning supplies were stored in the bathroom off of the hallway outside of the entrance to the kitchen, the chemical closet was unlocked, and bathroom door was unlocked. The deep fryer lid and side surfaces were covered in a thick layer of grease and food particles. The microwave oven contained dried substances on the inside. The can opener was covered with a dark brown gummy substance. The double ovens inside surfaces were covered in a black substance that was built up on all walls and doors. The stove's cooking surfaces were covered in a dried/burnt appearing black substance. The facility had a census of 35 with 35 of those residents receiving a tray from the kitchen. The findings include: 1. Review of the facility policy titled, FOOD STORAGE, dated 7/11/2024, revealed .Food items should be stored.in accordance with good sanitary practice.All products should be inspected for safety and quality and be dated.when open.Clean and sanitize outside of food bins daily.cleaning supplies must be stored in a separate locked area. Review of the facility policy titled, ICE MACHINE, dated 10/18/2018, revealed .Sanitation of equipment.Frequency: Daily.Wash exterior of machine with hot water and detergent. Rinse with clean water and cloth. Use sanitizing solution and clean cloth to sanitize.Frequency: Weekly. unplug the ice machine. Remove Ice. Wash inside of machine with approved detergent and hot water. Rinse with clean water. Then use sanitizing solution and clean cloth . Allow to air dry.refill ice.Frequency: 2x [times] per year.cleaning and sanitization of internal components usually done by maintenance.Dietary staff can not do actual cleaning of the internal components. Review of the facility policy titled, Cleaning Schedules, dated 8/31/2018, revealed .The Food and Nutrition Services Department through compliance with written, comprehensive cleaning schedules developed for the community by the Director of Food and Nutrition Services or other clinically qualified nutrition professional .A cleaning schedules shall be posted with tasks designated to specific positions in the department. 2. Observation in the kitchen on 8/11/2025 beginning at 9:15 AM, revealed the following: a. The walk in dry storage area had a dried white powdery substance on the floor and on top of 2 brown boxes located on a shelf. b. Sugar, flour, meal, and thickener were stored in large white plastic storage containers under a stainless-steel table with dried substances and loose particles on top of the lids and down the sides. c. The outside of the ICE machine had dried liquid that had spilled and had run down the front and sides of the ICE machine. The inside of the ICE machine contained several white streaks running down the inside walls around the door area. d. The can opener's surfaces were covered with a dark brown gummy substance. During an observation and interview in the kitchen with the RD on 8/12/2025 at 10:12 AM, revealed the following: a. Utensils were washed and placed to dry on a rack within 2 to 4 feet of dirty dishes and dishwasher area. Clean dishes were being stored in the dirty area by dishwasher. The Registered Dietitian (RD) was asked if this was an appropriate place to store clean dishes. The RD stated, No, they will need to be moved. b. The side-by-side refrigerator contained four opened and undated liquid containers. The RD confirmed an open date should be placed on any container upon initially opening it. c. The Dry storage area still had a white powdery substance spilled on top of the cardboard boxes and on the floor. The large white plastic storage containers containing the sugar, flour, meal, and thickener still had dried substances and loose particles on top of the lids and down the sides of the containers. The RD confirmed that their cleanliness was not acceptable. d. The can opener still had a dark brown gummy substance on it. e. The double ovens inside surfaces were covered in a black substance that is built up on all inside surfaces and doors. f. The stove surfaces were covered in a dried/burnt black substance. g. Chemicals were stored in the bathroom off of the hallway outside of the entrance to the kitchen, the chemical closet was unlocked, and the</p>		

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NAME OF PROVIDER OR SUPPLIER Lauderdale Community Living Center		STREET ADDRESS, CITY, STATE, ZIP CODE 215 Lackey Lane Ripley, TN 38063	

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>(continued on next page)</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on review of Quality Assurance and Performance Improvement (QAPI) Performance Improvement Plan meeting minutes, policy review, observation and interview, the QAPI Committee failed to recognize ongoing problems of inadequate supervision, failed to provide oversight to ensure an effective Infection Control Program was in place that protected residents from cross contamination and failed to ensure staff were competent in providing resident care. The QAPI committee failed to identify the root cause of the problems identified, failed to develop appropriate plans to correct the identified problems, failed to ensure systems and processes were implemented to address, correct, and maintain acceptable standards of practice, and failed to provide clinical guidance and oversight regarding the implementation of resident care policies and procedures. The QAPI Committee failed to ensure community medical equipment was disinfected to prevent the potential spread of infection when Licensed Practical Nurse (LPN) A failed to clean a multi-use blood glucose meter according to manufacturer's recommendations to prevent cross contamination after performing a blood glucose on Resident #2 which resulted in Immediate Jeopardy. The findings include: Review of the facility policy titled, QAPI Program and QAPI Committee Guideline, dated 4/10/2013, revealed .Each department along with the QAPI committee will identify critical items within that department's area of responsibility that must be monitored and reported. These items are those things most important to the successful functioning of the department, the quality of services provided to the resident, or areas that are inherently high risk .Each department will routinely gather and review data that reflects the current status of the critical items in their area .Once data has been gathered, trended, and compared .Root cause analysis is applied to discover the bottom line cause for system breakdown .Assess staff knowledge and performance . Review of the April 2025 QAPI meeting minutes revealed the Nursing departments review sheet had empty blanks for the month in the following areas: a. any concerns noted, b. body audits completed, c. trends d. Inservice's/skills checkoffs completed this month e. The DON (Director of Nursing) signature. There was no information related to infection control. Review of the May 2025 QAPI meeting minutes revealed all departments review sheets were blank, including Nursing. There was no information related to infection control. Review of the June 2025 QAPI meeting minutes revealed there was no review of the Nursing Department. There was no information related to infection control. During medication administration observations on 8/12/2025 at 11:30 AM, Licensed Practical Nurse (LPN) A performed a blood glucose check on Resident #2 then exited the room, cleaned the blood glucose monitor with a (Named) Hand Sanitizing Wipe which contained 70 percent (%) alcohol, then placed it on a clean barrier to dry. During an observation on 8/12/2025 at 4:38 PM, LPN A entered Resident #15's room with the blood glucose monitor and prepared to perform the Resident's blood glucose check. LPN A was stopped from performing the blood glucose check by the surveyor and asked if the blood glucose monitor had been cleaned. LPN A confirmed the monitor had not been cleaned immediately prior to the procedure and the last time it was cleaned was after monitoring Resident #2's blood glucose (with the hand sanitizing wipes). Refer to F880 Review of the August 2025 Ad/hoc Quality Assurance (QA)/QAPI Meeting review revealed that it was not completed until 8/14/2025, 2 days after the facility was notified of the Immediate Jeopardy at F880. The facility was unable to provide documentation of any education related to blood glucose monitoring or cleaning of blood glucose monitors prior to 8/12/2025. During an interview on 8/12/2025 at 7:05 PM, the DON was asked if anyone ever did medication pass audits and observed blood glucose checks with the floor staff. The DON stated, Yes, I believe at times we have done that. The DON was asked how often (this was done). The DON stated, Well, I think the RN [Registered Nurse] supervisor watches and helps with things like that. The DON was asked if the facility had an RN supervisor. The DON stated, At times there is a RN prn [as needed] and on some weekends. The DON confirmed there was no documentation of audits completed by the RN supervisor. During an interview on 8/14/2025 at 8:01 AM, the Administrator acknowledged the QAPI meeting minutes should not contain blank spaces. The Administrator was asked if after reviewing the minutes from the previous months, she felt the QAPI Program was effective. The Administrator stated, No, I don't. During a telephone interview on 8/14/2025 at 9:16 AM, the Medical Director was asked if he had been involved in a QAPI meeting to discuss the IJ. The Medical Director stated, We were going to do that yesterday [8/13/2025], but they pushed it back and rescheduled it for some time next week. I'm not sure why they changed it.</p>		

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on (Named Glucometer-a device/meter used to check blood sugar levels with the use of a blood sample) User's Guide review, policy review, job description review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when a multi-use blood glucose meter was not cleaned and disinfected with an Environmental Protection Agency (EPA) approved disinfecting wipe to prevent the cross-contamination of bloodborne pathogens for 2 of 2 (Residents #2 and Resident #15) sampled residents reviewed for blood glucose monitoring. Licensed Practical Nurse (LPN) A failed to clean and disinfect the multi-use blood glucose meter before and after use on each resident in accordance with User's Guide recommendations and facility policy. LPN B failed to perform hand hygiene and glove changes between medication administration of different routes, failed to clean, rinse, and dry a nebulizer mask after use, and failed to perform hand hygiene when changing gloves during resident care for 1 of 4 (Resident #8) residents reviewed for medication administration. LPN B failed to clean soiled items removed from a resident's room prior to storing in a medication cart and failed to clean the medication cart after placing soiled items on it for 1 of 2 (Hall B) medication carts. The facility failed to establish and implement a program to identify, report, investigate, and control infections and communicable diseases when they failed to track infections by organism for 4 of 4 months (April, May, June, and July 2025) reviewed for tracking and trending of infections. The facility's failure to ensure staff properly disinfected the blood glucose meter that was used for multiple residents, in accordance with recommendations and the facility's policy, placed the residents at risk for potential contamination with bloodborne pathogens and the likelihood to cause serious injury, harm, impairment, and/or death resulted in Immediate Jeopardy. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to appropriately clean and disinfect a multi-use blood glucose meter during medication administration for Resident #2 and #15. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy for F880 on 8/12/2025 at 7:18 PM, in the Conference room. The facility was cited Immediate Jeopardy at F-880. The facility was cited at F-880 at a scope and severity of J. The Immediate Jeopardy for F-880 began on 8/12/2025 and continued through 8/13/2025. The Immediate Jeopardy was removed 8/14/2025. An acceptable Removal Plan, which removed the immediacy of the jeopardy, was received on 8/13/2025 at 4:19 PM, and was validated onsite by the surveyors on 8/14/2025 through review of in-services, audits, and staff interviews conducted on all shifts. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility's policy titled, .Fingerstick Glucose, dated 3/19/2012, revealed . Purpose.To obtain a blood sample to determine the resident's blood glucose level.Preparation.Disinfected blood glucose meter.Ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses.Clean and disinfect reusable equipment between uses according to the manufacturer's instructions with an EPA registered disinfectant (follow manufacturers instructions for application) and according to current infection control standards of practice. After cleaning, place on a barrier and/or return to designated storage container. Review of the (Named Glucometer) User's Guide with a revised date of 3/2024, revealed .Cleaning and Disinfecting Your [Named Glucometer].Cleaning and disinfecting your meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter and lancing device surface, so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface.Cleaning and Disinfecting Your Meter.Wash hands with soap and water and dry thoroughly.Inspect for blood, debris, dust, or lint anywhere on the meter or lancing device.To clean the meter, use a moist (not wet) lint-free cloth dampened with a mild detergent. Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port.To disinfect your meter, clean the meter with one of the validated .EPA registered wipes. Wipe all external areas of the meter or lancing device including both front and back surfaces until visibly clean. Avoid wetting the meter test strip port. Allow the surface of the meter or lancing device to remain wet at room temperature for the contact time listed on the wipe's directions for use.Wipe meter dry or allow to air dry Wash hands with soap and water and dry thoroughly If the meter or lancing device is being operated by a</p>		

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<p>F 0949</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide behavior health training consistent with the requirements and as determined by a facility assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to provide Behavioral Health Training to staff caring for 3 of 3 (Resident #8, #25, and #30) sampled residents reviewed for Dementia. The findings include: 1. Review of medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Hypertension, and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE], revealed a Brief Interview for Mental Statue (BIMS) score of 4, which indicated Resident #8 was severely cognitively impaired. 2. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Dementia, Unspecified Mood (Affective) Disorder, Diabetes, and Epilepsy. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #25 was severely cognitively impaired. 3. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Dementia, Hemiplegia, Cerebral Infarction, Diabetes, and Depression. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 6, which indicated Resident #30 was severely cognitively impaired. The facility was unable to provide documentation of Behavioral Health Training for staff. During an interview on 8/12/2025 at 3:05 PM, the Regional Nurse confirmed that the facility had no Dementia management training. The Regional Nurse was asked if the facility utilized a computerized system that provides in-service trainings to the staff. The Regional Nurse confirmed the facility uses a (named) computer system to provide staff training, but it does not include training related to Dementia care. During an interview on 8/13/2025 at 9:22 AM, Certified Nursing Assistant (CNA) D confirmed that she did not receive training on how to care for residents with Dementia. During an interview on 8/13/2025 at 10:03 AM, CNA F confirmed that another CNA had spoken with her about care of Dementia residents during orientation, but that she had not had formal training provided by the facility related to caring for residents with Dementia or behavior management. During an interview on 8/13/2025 at 9:59 AM, CNA D stated .today is my 4th day here .no [dementia] training when [I] hired in . During an interview on 8/13/2025 at 10:03 AM, CNA F stated that she had worked in the facility about 2 weeks. CNA F was asked if she had Dementia training on hire. CNA F stated, .yes .they talked to me about it . CNA F was asked who talked with her about it (Dementia training). CNA F stated, .another aide when I got on the floor . During an interview on 8/13/2025 at 10:07 AM, Housekeeper H stated she will have worked at the facility .2 years next month . Housekeeper H was asked if she had received Dementia training. Housekeeper H stated, .No ma'am .</p>		