

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Waters of McKenzie A Rehabilitation & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 14510 US-Highway 79 MC Kenzie, TN 38201	

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** 44724</p> <p>Based on facility policy, medical record review, observation and interview the facility failed to ensure dignity and resident choice was met for 1 (Resident #33) of 1 sampled resident reviewed for activities of daily living.</p> <p>The findings include:</p> <p>1. Review of the undated facility policy titled, CALL LIGHTS, revealed, .It is the policy of the facility to have a system in place to allow the staff to respond promptly to a resident's call for assistance .Never make the resident feel as though you are too busy to give assistance. If you yourself cannot provide the requested assistance, assure the resident that you will take their request to the appropriate staff. Follow through with this commitment and follow up to see if the resident had the need met. NEVER TURN OFF A CALL LIGHT THEN FAIL TO SEE THAT THE RESIDENT'S REQUEST WAS ADDRESSED</p> <p>Review of the undated facility policy titled, Resident Rights, revealed, .The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident .</p> <p>2. Review of the medical record revealed Resident #33 was admitted on [DATE], with diagnoses which included Muscle Wasting and Atrophy, Chronic Pain Syndrome, Need for assistance with personal care, and Anorexia.</p> <p>Review of the Annual Minimum Data Set assessment (MDS) dated [DATE], revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review revealed Resident #33 was dependent for chair/bed-to-chair transfer.</p> <p>During an observation and interview on 4/14/2025 at 3:50 PM, Resident #33 stated, leave the door open I want to see how long it takes her to come down here and put me to bed . Resident #33 turned on his call light at 3:50 PM.</p> <p>Observation on 4/14/2025 at 3:51 PM, revealed 2 staff members sitting at nurses' station where call light was sounding.</p> <p>Observation on 4/14/2025 at 3:57 PM, Resident #33 still awaiting to be placed in bed.</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>Observation on 4/14/2025 at 3:58 PM, Wound Nurse answered the call light and told the resident I will go see if I can find your Certified Nursing Assistant (CNA).</p> <p>Observation on 4/14/2025 at 3:59 PM, Resident #33 continued to wait to be placed in his bed.</p> <p>Observation on 4/14/2025 at 4:04 PM, Resident #33 had rolled into the hall still awaiting to be placed in bed.</p> <p>Observation on 4/14/2025 at 4:05 PM, a CNA takes him into his room then walked back out.</p> <p>Observation on 4/14/25 at 4:08 PM, Resident #33 continued to sit in his wheelchair by his bed.</p> <p>Observation on 4/14/25 at 4:11 PM, Resident #33 continued to be up in his wheelchair.</p> <p>Observation on 4/14/2025 at 4:12 PM revealed 3 staff members are sitting at the nurse's station.</p> <p>Observation on 4/14/2025 at 4:13 PM, the Wound Nurse told Resident #33, I am looking for the CNA so I can help put you to bed.</p> <p>Observation and interview on 4/14/2025 at 4:14 PM, Resident #33 stated, .this is always a problem when I get back from smoking .</p> <p>Observation on 4/14/2025 at 4:16 PM, Resident #33 had been waiting 26 minutes to be put to bed.</p> <p>Observation on 4/14/2025 at 4:16 PM, the CNA was standing at the desk which he told at 4:05 PM, he wanted to go to bed.</p> <p>Observation on 4/14/2025 at 4:19 PM, Resident #33 continued to remain up in his room in his wheelchair.</p> <p>During an interview on 4/15/2025 at 8:08 AM, Resident #33 stated, .I finally went to bed after about 2 hours. It seems to happen every time that CNA is here .</p> <p>Observation on 4/15/2025 at 1:45 PM, Resident #33's call light was on and sounding at the nurse's station. Resident #33 stated, .I am waiting to go back to bed .I went to smoke at 1:00 PM, I been waiting about 15 minutes .</p> <p>Observation on 4/15/2025 at 1:48 PM, CNA E answered Resident #33's call light and told the resident let me go see if I can find your CNA, referring to the CNA assigned to him today. CNA E goes to room [ROOM NUMBER] where his CNA was providing care. CNA E told the CNA he was wanting to go to bed through the door. CNA E stated, I will let him know you're in another room. CNA E goes back to Resident #33's room and informed him the CNA was in another resident's room providing care.</p> <p>Observation on 4/15/2025 at 1:54 PM, Resident #33 continued to be up in his wheelchair waiting to be placed in the bed.</p> <p>(continued on next page)</p>		

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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>Observation on the hall on 4/15/2025 at 1:58 PM, CNA F (CNA assigned to Resident #33) came out of room [ROOM NUMBER] where she had been providing care. CNA F goes to Resident #33's room and told the resident .I will have to go find someone to help .</p> <p>Observation on hall on 4/15/2025 at 2:05 PM, CNA F and another care giver goes into Resident #33's room. Resident #33 had waited 20 minutes.</p> <p>Observation on 4/15/2025 at 2:10 PM, Resident #33 was in the bed.</p> <p>During an interview on 4/16/2025 at 11:50 AM, the Director of Nursing (DON) was asked what she expected staff to do when a call light is on. The DON stated, .I would expect them to answer it timely .they should meet the residents need .a CNA should not say let me find your CNA .the call light should be left on until their needs are met .I would expect the staff to provide the care even if that was not their resident that was to long for a resident to wait to go to bed .</p>		

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to assess 1 of 1 resident (Resident #197) reviewed for self-administration of medication.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the undated facility policy titled, Medication Self Administration, revealed .procedures for determining if the resident can safely self-administer .Residents .will be assess at the time of admission .to determine if the practice is safe, based on the results of the Resident Assessment-Self-administration Tool . assessment results will be discussed with the attending physician and an order obtained to self-administer if appropriate . 2. Review of the medical record revealed Resident #197 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory Failure, and Liver Disease. <p>Basic Interview for Mental Status had not been assessed due to recent admit and in process.</p> <p>Review of the Physician Order Sheet dated April 2025, revealed .Levalbuterol HCl Nebulization Solution 0.63 MG [milligrams] /3ML [milliliter] 6 ml inhale orally via nebulizer .related to Chronic Obstructive Pulmonary Disease .</p> <p>Observation in the Resident's room on 4/15/2025 at 7:41 AM, Resident #197 was sitting on the edge of the bed with the nebulizer mask on and treatment going, and no nurse was present in the room.</p> <p>Observation on 4/15/2025 at 7:49 AM, Licensed Practical Nurse (LPN) A entered Resident #197's room and discontinued the nebulizer treatment.</p> <p>During an interview on 4/15/2025 at 1:08 PM the Director of Nursing (DON) confirmed that there should be an assessment for self-administration and a physician order for a resident to self-administer medications.</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** 44724</p> <p>Based on medical record review, observation, and interview the facility failed to implement interventions on care plan for 1 of 3 (Resident #26) sampled residents reviewed for accidents.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #26 admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Dementia, Osteoarthritis, Difficulty in Walking, and History of Falling.</p> <p>Review of the Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #26 had a Brief Interview for Mental Status (BIMS) score of 6 which indicated severe cognitive abilities.</p> <p>Review of Resident #26's Progress Note dated 8/8/2024 revealed, .Note Text: Resident witnessed on floor beside bed. Bed was in low position. She states that she rolled over and slid onto the floor. She was lying on her right hip .Arms noted under her upper body. Legs straight .Nurse and CNA had been in resident's room [ROOM NUMBER] min prior to fall. She was lying in bed, facing the wall at that time .</p> <p>Review of Resident #26's current comprehensive care plan revealed, .I'm at Risk for Falls as evidenced by the following risk factors and potential contributing Diagnosis: COPD .emphysema; acute respiratory failure with hypoxia; anxiety disorder; major depressive disorder; CHF [Congestive Heart Failure]; difficulty in walking history of falls; need for assistance with personal care; reduced mobility; peripheral vascular disease; unspecified dementia . Continued review of Resident #26's care plan revealed an intervention dated 8/8/2024 for define borders to the bed.</p> <p>During an observation and interview on 4/14/2025 at 2:25 PM, Family Member (FM) G reported she has had numerous falls since she admitted . FM G pulled up Resident #26's sleeve and she was noted to have bruising to the right elbow and 3 steri strips (used to help seal a wound by pulling the two sides of skin together) were noted.</p> <p>Observation on 4/15/2025 at 10:05 AM, Resident #26 was in the bed sleeping. No device or mattress noted to follow the care plan intervention for define borders of bed to help prevent falls.</p> <p>During an observation and interview on 4/15/2025 at 10:10 AM, Certified Nursing Assistant (CNA) F was asked what would be in place to meet the fall intervention for defined borders for her bed. CNA F stated, .we use a pool noodle sometimes, bolsters or the mattress may be raised on the edge . CNA F was asked to assess Resident #26's bed for the defined border. CNA F verified Resident #26 does not have anything to define the borders to her bed.</p> <p>(continued on next page)</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>During an observation and interview on 4/15/2025 at 10:15 AM, the MDS Coordinator was asked what would consist of defined borders on a fall care plan. MDS Coordinator stated, .either pool noddle, rolled up blanket, or a certain kind of mattress . The MDS Coordinator was asked to observe Resident #26's bed and asked if the resident had the intervention in place to define the borders of her bed. The MDS Coordinator stated, .no, it should be on the bed .</p> <p>During an interview on 4/15/2025 at 10:20 AM, the Director of Nursing was asked if a resident has an intervention for define borders to prevent falls should it be followed. The DON stated, .Yes, it should be on the bed .</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51670</p> <p>Based on facility policies, record review, observations, and interviews the facility failed to provide Oxygen therapy as ordered by the Physician for 1 of 1 (Resident #13) reviewed for Respiratory Care.</p> <p>The findings include:</p> <p>1. Review of the undated facility policy titled, Oxygen Administration Guidelines, revealed, .Review order for oxygen administration to include .flow rate .</p> <p>Review of the facility policy titled, Guidelines For Physician Orders, dated 6/18/2023, revealed .It is the policy of the facility to follow the orders of the physician .All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility .</p> <p>2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Acute Ischemic Heart Disease, Occlusion and Stenosis of Left Carotid Artery, Cerebral Infarction, and Hypertension.</p> <p>Review of the Care Plan dated 1/28/2025 revealed .Administer O2 [oxygen] as ordered per MD [Medical Doctor] .Observe concentrator and/or E [emergency] tank for correct setting of liter .</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 1, which indicated that Resident #13 was severely cognitively impaired. Further review revealed no shortness of breath and oxygen therapy was received.</p> <p>Review of the Physician's Orders dated 3/29/2025, revealed .Oxygen 3 L [liter] PRN as needed for SOB [Shortness of Breath] 3L prn to keep O2 Sat above 91% [percent] .</p> <p>Review of the Medication Administration Record (MAR) dated 4/2025, revealed no documentation of administration of PRN O2.</p> <p>During observations in Resident #13's room on 4/14/2025 at 12:00 PM and 3:09 PM and 4/15/2025 at 7:49 AM, revealed Oxygen concentrator set on 1.5-2 L.</p> <p>During interview and observation on 4/15/2025 at 8:02 AM Licensed Practical Nurse (LPN) C was asked what Resident #13 O2 orders was, LPN C stated, 2L. LPN C was asked to show the O2 orders, LPN C stated, .it changed to 3L . LPN C was asked to show what Resident #13 O2 was set on, LPN C changed O2 setting to 3L.</p> <p>During an interview on 4/15/2025 at 4:33 PM the Director of Nursing (DON) confirmed that staff was expected to follow Physician orders for O2 settings.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724</p> <p>Based on facility policy review, medical record review, observation and interview, the facility failed to accommodate dietary preferences for 2 of 2 (Resident #33 and #42) sampled residents reviewed for dietary preferences.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the undated facility policy titled, RESIDENT FOOD PREFERENCES, revealed .Food preferences will be honored unless contraindicated .The facility will offer residents food choices and preferences to include .personal preferences .The Food Service Manager or designee will interview the resident and obtain their food preferences .Food preferences will be updated accordingly and will be noted in the resident's tray card .The staff may follow the list of resident's food choices and preferences . Review of the medical record revealed Resident #33 was admitted on [DATE], with diagnoses which included Muscle Wasting and Atrophy, Chronic Pain Syndrome, Need for assistance with personal care, and Anorexia. <p>Review of the Nutritional Risk Quarterly Review dated 6/17/2024, revealed no discussion with Resident #33 related to his food preferences.</p> <p>Review of the Nutritional Risk Quarterly Review dated 9/11/2024, revealed no discussion with Resident #33 related to his food preferences.</p> <p>Review of the Nutritional Risk Quarterly Review dated 12/4/2024, revealed no discussion with Resident #33 related to his food preferences.</p> <p>Review of the Nutritional assessment dated [DATE], revealed food preferences for French toast and pancakes. Continue review revealed .List any Food/Beverage Dislikes See Tray Card .</p> <p>Review of the Annual Minimum Data Set assessment (MDS) dated [DATE], revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review revealed Resident #33 required setup or clean-up assistance with eating. Further review revealed Resident #33 had no significant weight loss in the last month or 6 months.</p> <p>Review of the current comprehensive care plan revealed, .My history indicates that I have experienced serious trauma during my lifetime. Specifically, trauma related to .Homelessness, living through depravation, going without food .</p> <p>Review of Resident #33's printed tray card dated 4/15/2024 revealed no area for likes or dislikes.</p> <p>During an interview on 4/14/2025 at 9:15 AM, Resident #33 was asked if breakfast was good. Resident #33 stated, .I haven't seen a good breakfast, pancakes and french toast is what I like but oatmeal is what I got .</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in the dining room on 4/15/25 07:49 AM, residents were noted to have pancakes on their breakfast tray.</p> <p>During an interview on 4/15/25 at 8:36 AM, Resident #33 was asked how his breakfast was this am. Resident #33 stated, .got to go with what they cook .just take what you can get . Resident #33 had eaten his eggs and half of his oatmeal.</p> <p>3. Review of the medical record revealed Resident #42 admitted to the facility on [DATE], with diagnoses which included Rhabdomyolysis, Dementia, Essential Hypertension, and Dehydration.</p> <p>Review of Resident #42's admission Progress Note dated 2/27/2025 revealed, .The resident has a good appetite but does not like to drink tea .</p> <p>Review of the Admission MDS dated [DATE], revealed Resident #42 had a BIMS score of 8 which indicated moderate cognitive impairment. Continued review revealed Resident #42 required setup or clean-up assistance with eating. Further review revealed Resident #42 had weight loss noted prior to his admission.</p> <p>Review of the current comprehensive care plan revealed, .At possible risk for dehydration with signs and symptoms R/T [related to]: history of dehydration poor po [by mouth] intake at times .</p> <p>Review of Resident #42's Nutritional assessment dated [DATE] revealed the Food Preferences were not marked, list of food/beverage dislikes was blank, and comments related to food preferences noted .See tray card . Further review revealed RD [Registered Dietician] Summary noted Resident #42 remains at risk for compromise in nutrition and hydration status related to altered nutrition related lab values and being on meds that may have nutritionally significant side effects.</p> <p>Observation on 4/14/2025 at 12:14 PM, Resident #42 was noted to have tea on his tray. Continued review revealed Resident #42 had eaten 100% (percent) of his meal and had not touched his tea.</p> <p>Review of Resident #42's printed tray card dated 4/15/2024 revealed no area for likes or dislikes.</p> <p>During an interview on 4/15/2025 at 3:10 PM, the Dietary Manager was asked about the 3/6/2025 Nutritional Assessment being blank for beverage dislikes. The Dietary Manager stated, .I don't do the preferences in [Named Computer system], I don't have access to it .I do them on paper . The Dietary Manager searches through her filed papers and stated, .I haven't done a preference on him. I usually do it when they admit .No he shouldn't have received tea on his tray .</p> <p>(continued on next page)</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/15/2025 at 3:15 PM, the Dietary Manager was asked if Resident #33's food preferences noted he enjoyed pancakes and french toast should he receive those foods at breakfast. The Dietary Manager stated, .he never has said he wanted them daily . The Dietary Manager was asked to show this surveyor his tray card. Review of the tray card with the Dietary Manager revealed no likes or dislikes noted on the tray card. The Dietary Manager stated, .It's not going to show the likes and dislikes . The Dietary Manager was asked if staff prepare the trays by the review of the tray cards. She stated, yes. The Dietary Manager and Regional Dietary Manager was asked how the staff members who prepare the trays on the tray line would know what foods the resident prefers. The Dietary Manager stated, .I see what you are saying but the Certified Nursing Assistants would come back and get something else if they didn't like it .If he liked pancakes, he should receive them when we have them .</p> <p>During an interview on 4/15/2025 at 4:00 PM, the Administrator was asked if the food preference policy should be followed. She stated, Yes, it should be followed. The Administrator was shown Resident #33 and Resident #42's tray card which revealed no likes or dislikes. The Administrator stated, .usually tray cards show the likes and dislikes I will have to check with [Named Dietary Company] to see why the cards are not showing that .</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>49311</p> <p>Based on facility document review, observation, and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions when 1 of 1 ice machine was observed to have a dark slimy buildup on the inner seal. The census was 46 with 44 residents receiving a tray from the kitchen.</p> <p>The findings:</p> <p>1. Review of the undated, facility document titled, Physical Plant-Monthly Inspections, revealed .Ice Machines: Clean filters and check water filter and observe for proper operation. Look for any calcium, lime, or algae. Check to ensure it is in a clean and sanitized state. This includes all ice machines throughout the facility including Dietary .</p> <p>2. Observation and interview on 4/14/2025 at 8:44 AM, with the Dietary Manager (DM) revealed the ice machine had a black, slimy substance all around the inside seal. The DM was asked who was responsible for cleaning the ice machine. The DM stated, Maintenance. The DM was asked if it was clean. The DM stated, No.</p> <p>Observation and interview on 4/15/2025 at 8:38 AM, with the DM revealed the ice machine had a black, slimy substance all around the inside sea. The DM was asked if the ice machine had been cleaned. The DM stated, I told maintenance, and he must not have cleaned it. The DM stated that she would tell him again and we could come back to check it later.</p> <p>During an interview on 4/15/2025 at 4:15 PM, the Regional Dietary Manager (RDM) was asked who was responsible for cleaning the ice machine. The RDM stated, Maintenance. The RDM was asked who is ultimately responsible for the ice machine. The RDM stated kitchen .</p> <p>During an interview on 4/15/2025 at 5:06 PM, the Administrator was asked if there should be black slime on the ice machine. The Administrator stated, Absolutely not.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Waters of McKenzie A Rehabilitation & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 14510 US-Highway 79 MC Kenzie, TN 38201	
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 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** 48285</p> <p>Based on policy review, record review, observations and interviews the facility failed to ensure staff followed hand hygiene guidelines during wound care for 1 of 1 (Resident #13) reviewed for wound care.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, Dressing Change, Clean, dated 1/1/2024, revealed .Procedure Purpose .To prevent infection and spread of infection .Perform hand hygiene .put on .disposable gloves .Cleanse wound .Apply prescribed medication .Apply dressings .Remove gloves .Wash hands . 2. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Muscle Weakness, Abnormal Posture, Hemiplegia and Hemiparesis, and Low Back Pain. <p>Review of Care Plan dated 1/28/2025, revealed .Skin .has disruption of skin surface .to labia .disruption of skin surface will remain free from infection .</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 1, which indicated that Resident #13 was severely cognitively impaired.</p> <p>Review of the Physician's orders dated 3/13/2025, revealed .Clean sacrum with wound cleanser. Pat dry. Apply zinc oxide paste and apply non pressure dressing to sacrum daily and PRN [as needed]. every day shift for pressure injury healing AND every 12 hours as needed for pressure injury healing .</p> <p>Review of the Physician's orders date 4/15/2025, revealed .Apply layer of Dermaphor to right labia Q [every] shift and PRN every shift for protection AND as needed for protection .</p> <p>During observation in Resident #13's room on 4/16/2025 at 9:22 AM, revealed Licensed Practical Nurse (LPN) D touched the paper towel dispenser after washing hands, then preceded to resident's bedside to begin wound treatment. LPN D reached into uniform pocket with gloved hand to retrieve a marker, used the marker on clean dressing, and laid marker on bedside table without a barrier, applied dressing to sacral wound, changed gloves and then preceded to address the next wound. LPN D removed the marker from bedside table and placed into uniform pocket, then exited the resident's room and applied Alcohol Based Hand Rub (ABHR) to hands.</p> <p>LPN D failed to perform proper hand hygiene after touching paper towel dispenser, after reaching in pocket, between wound care treatments, and after completing all wound care. LPN D failed to sanitize marker prior to exiting room to prevent cross contamination.</p> <p>During an interview on 4/16/2025 at 11:27 AM, LPN D confirmed that staff should not touch the paper towel dispenser after washing hands, staff should not reach into uniform pocket with gloved hand, proper hand hygiene should be performed between wounds, and multiuse items should be sanitized after use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445357	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Waters of McKenzie A Rehabilitation & Nursing Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 14510 US-Highway 79 MC Kenzie, TN 38201	
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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 4/16/2025 at 11:53 AM, the Director of Nursing (DON) confirmed that staff should not touch the paper towel dispenser after washing hands, staff should not reach into uniform pocket with gloved hand, proper hand hygiene should be performed between wounds and at end of wound care treatment, and multiuse items should be sanitized after use.</p> <p>51670</p>		