STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445366	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W D Bill Manning Tennessee State Veterans Home	2865 Main Street Humboldt, TN 38343

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to maintain and ensure the prevention and spread of infection when 1 of 7 (Licensed Practical Nurse (LPN A) nurses failed to wear Personal Protective Equipment (PPE) during medication administration for 1 of 9 (Resident #15) sampled residents reviewed. The findings include: 1. Review of the facility policy titled, Infection Control Manual .Enhanced Barrier Precautions (EBP), revealed dated 4/25/2024, revealed .Enhanced Barrier Precautions[EBP] refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] expand the use of PPE [Personal Protective Equipment] to donning of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following.wounds .indwelling medical devices. 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Dementia, and Dysphagia. Review of the Minimum Data Set assessment dated [DATE], revealed Resident #15 scored a 3 on the Brief Interview for Mental Status assessment, which indicated he had severely impaired cognition and had a feeding tube. Review of the Physician Order dated 4/27/2026 revealed .Enhanced Barrier Precautions. Review of the Physician Order dated 5/18/2026, revealed .Alprazolam [a medication for anxiety] Oral Tablet 0.5 MG [milligram] .Give 1 tablet via [by] Peg-tube [percutaneous endoscopic gastrostomy (PEG) a soft, flexible tube that delivers nutrition, fluids, and medications directly into the stomach] in the afternoon for Anxiety . Observation and interview in Resident #15's room on 6/2/2026 at 2:39 PM, revealed Licensed Practical Nurse (LPN) A performed hand hygiene, pulled the Alprazolam from the North Medication Cart's drawer, put the medication in a medication cup, added water to the medication cup, and poured water in a plastic cup. After the medication was dissolved in the water, LPN A performed hand hygiene, donned gloves, and gathered supplies. LPN A entered Resident #15's room, paused the enteral feeding, disassembled the enteral tubing connection from the peg site tubing and placed the enteral tubing over the enteral feeding pole. LPN A listened for placement with a stethoscope, LPN A connected the syringe to the peg site, checked for residual (is the amount of liquid remaining in the stomach), returned 7 cc (cubic centimeters) of the residual back into the stomach with the syringe, poured 30 cc of water into the syringe and administered it by gravity. LPN A poured the medication into the syringe and administered it by gravity, poured 30 cc of water into the syringe and administered it by gravity, removed the syringe, and connected the enteral tubing to peg tube. LPN A entered the resident's bathroom, placed the cups in the trash, rinsed the syringe with water and placed on a paper towel barrier. LPN A removed her gloves, washed her hands and returned to the medication cart. LPN A was asked what should she have worn when giving medication through the peg site. LPN A stated, Gloves. LPN A failed to wear proper PPE when administering medication through the peg tube. During an interview on 6/3/2026 at 2:23 PM, the Director of Nursing (DON) was asked what should staff wear when administering medication through a peg tube. The DON stated, They should wear gown and gloves.

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