STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445372	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hardin County NH	935 Wayne Road Savannah, TN 38372

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909 Based on policy review, medical record review, and interview, the facility failed to conduct care plan conference with the resident and/or family representative for 1 of 12 (Resident #28) sampled residents reviewed for care plan conferences. The findings include: 1. Review of the facility policy titled, Care Plan Meeting dated 12/2024, revealed .A Care Plan meeting is conducted to demonstrate to the resident, family, and resident representative that the organization is dedicated to the provision of person-centered care to achieve the resident's highest practicable well-being and outcomes of the resident's ongoing health and safety concerns .MDS Coordinator or designee will set the appointment date and time with the resident, family/representative .The Interdisciplinary Team (IDT) will introduce themselves and explain their roles on the care team. The IDT will obtain additional pertinent information regarding the resident's clinical status, prior living conditions, and the presence of family/local support to determine the resident's strengths and needs .The team will encourage the resident .resident representative to include any personal and cultural preferences to be incorporated into the goals of care during the full life conference .Educate the resident and/or representative on the realistic duration, frequency, and goals of any rehab and/ or nursing goals . 2. Review of the medical record revealed Resident #28 was admitted to facility on 2/9/2024, with diagnoses including Emphysema, Chronic Obstructive Pulmonary Disease, and Adult Failure to Thrive. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #28 was cognitively intact. Review of comprehensive MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #28 was cognitively intact. Review of the facility's Care Plan Conference sign in sheet dated 9/11/2024, revealed the Resident or responsible party (RP) where not listed in attendance for the meeting. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide documentation that a Care Plan Conference was conducted with the Resident or Responsible Party (RP) regarding the quarterly Care Plan Conference dated 5/14/2024, the quarterly Care Plan Conference dated 8/12/2024, the significant change Care Plan Conference dated 9/11/2024, and the quarterly Care Plan Conference dated 11/11/2024. During an interview on 1/21/2025 at 3:07 PM, Resident #28 was asked about being invited to care plan meetings. Resident #28 stated, .I've never been to one, neither has my daughter . During an interview on 1/22/2025 at 2:52 PM, the MDS Coordinator was asked can you provide me documentation of Resident #28's involvement in care plan meetings. The MDS Coordinator confirmed Social Services sends invites to the family and everyone in attendance signs the care plan conference sheet. During an interview on 1/22/2025 at 3:17 PM, the Social Services Director was asked if the Care Plan meeting was documented in the electronic medical record (EMR). Social Services stated, I didn't, I should have. During an interview on 1/23/2025 at 4:24 PM, the Director of Nursing (DON) was asked if there was documentation to show a resident or resident representative planned to participate in and were present for care plan meetings. The DON confirmed a sign in sheet is completed for anyone in the meetings including the resident and resident family members. If family joins by phone that should also be documented on that sheet. The DON was asked how residents and resident representatives are notified of an upcoming care plan meeting The DON stated, . [Social Service Director] does that . The facility failed to provide documentation that the Resident and/or RP were included in Care Plan Conferences for 5/14/2024, 8/12/2024, 9/11/2024, and 11/11/2024.

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F 0689 Level of Harm - 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** 30974 Based on facility policy review, medical record review, facility investigation, observation, and interview, the facility failed to provide adequate supervision and assistance to prevent fall accidents for 1 of 8 residents (Resident #3) reviewed for falls and failed to perform fall assessments per facility policy for 6 of 8 residents (Resident #5, #12, #14, #22, #26, and #187) reviewed for falls. The facility failed to implement the care plan intervention of staying with Resident #3 while toileting on 8/13/2024, when Resident #3 fell from the toilet and sustained an oblique (neither parallel nor at right angle, slanting) impaction fracture (bone fracture when pressure is applied to both ends of a bone, causing it to split and jam together) of the proximal tibial metaphysis (the enlarged lower part of the shinbone that meets the knee joint) and a nondisplaced transverse impaction fracture of the fibular neck (broken bone still aligned in the narrow part of bone just below the knee joint), resulting in Actual Harm to Resident #3. The Findings Include: 1. Review of the facility's policy titled, Falls, revised 12/2024, revealed .The intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls .All residents will have a fall risk assessment on admission/readmission, quarterly, annually, and with a significant change of condition to identify risk for falls . The care plan will be reviewed following each fall, quarterly, annually, and with a significant change in condition .Care Plan goals and interventions will be revised as applicable . 2. Review of the medical record revealed Resident #3 was readmitted to the facility on [DATE], with diagnoses including Fracture of Upper End of Left Tibia, Difficulty in Walking, Pain in Left Lower Leg, and History of Falling. Review of the Care Plan for Resident #3 revealed a fall intervention dated 4/15/2024, for staff to remain with resident while in the bathroom. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated Resident #3 was severely cognitively impaired, required maximal assistance with toileting and transfers, and was occasionally incontinent of urine. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Progress Notes dated 8/13/2024, revealed, .3:58 PM . Called to [Resident #3]'s room, resident is on the floor, observed resident sitting on the floor back against the toilet bowl and wall. Left leg folded under resident .assist to wheelchair, noted swelling and bruising to area under L [left] knee .MD [Medical Director] and [Family Member (FM) FF] notified of incident. No orders at this time .4:20 PM .order received for a L Knee, L Tibia Fibula [the two long bones in the lower leg] Xray .8/13/2024 8:40 PM .Received results from xrays on LLE [Left Lower Extremity]. Findings showed an oblique impaction fracture of the proximal tibial metaphysis and a nondisplaced transverse impaction fracture of the fibular neck. [Director of Nursing (DON)] .notified. Dr [Doctor] .notified and order to send to ER [emergency room] for eval [evaluation] .FM [Family Member FF] arrived at nursing home 9:15 PM Dr .called back to give order for Tramadol [pain medication] 50mg [milligram] 0.5 or 1 tab PO [by mouth] Q [every] 6HRS [hours] PRN [as needed] for moderate to severe pain and to Send to ER as long as [FM FF] approves. Resident given Tramadol 50mg po at 9:30 PM. Transferred to stretcher and taken to ER at 9:35 PM with [FM FF] present . Review of the facility's Incident Investigation dated 8/13/2024, revealed .noted resident [#3] on the floor of her bathroom .noted large bruise to L [left] knee area .Mental Status .oriented to self, confused to time and place .IDT [Interdisciplinary Team] investigated incident. [Certified Nursing Assistant (CNA) A] stepped away from resident while on toilet to check on another resident. Resident attempted to transfer unassisted due to cognitive impairment. Intervention: re-educate staff to constantly observe resident while toileting . Review of the Medication Administration Record (MAR) dated 8/2024, revealed Resident #3 received Tramadol 25 mg on 8/13/2024 post fall for a pain level of 10 on a pain scale of 1-10 (1 being the lowest and 10 being the highest). Review of Hospital #1's History and Physical Exam for Resident #3 dated 8/14/2024, revealed .EMS [Emergency Management Service] from [Hospital #2] .with complaint of left lower extremity pain. Associated symptoms include right distal thigh pain .was told she was getting off the BSC [bedside commode] about 1430 [2:30 PM] 8/13/24 [2024] and fell getting up. Her left lower extremity is bruised and dark in color .XR [x-ray] left tibia/fibula impression .There is an oblique impaction fracture of the proximal tibial metaphysis. There is also a nondisplaced transverse impaction fracture of the fibular neck. There is associated soft tissue swelling, XR right femur. No acute abnormality .Left tibia-fibula fracture was suspected, patient transferred for higher level of care. On imaging .appears to be possible horizontal fracture .Patient admitted for possible left tibial fracture, to be seen by orthopedics and consideration given to conservative versus operative intervention . Review of the MAR dated 8/2024, revealed Resident #3 received 21 doses of Tramadol 25 mg PRN from 8/15/2024-8/31/2024, with a pain range from 1-7. Further review revealed Resident #3 received 8 doses of Tylenol 325 mg PRN from 8/16/2024-8/31/2024. Review of the MAR dated 9/2024, revealed Resident #3 received 21 doses of Tramadol 25 mg PRN and 8 doses of Tylenol 325 mg tablet PRN. Review of the MAR dated 10/2024, revealed Resident #3 received 12 doses of Tramadol 25 mg PRN and 7 doses of Tylenol 325 mg tablet PRN. Review of Resident #3's Physician Orders dated 1/2025 revealed an order for a leg brace to be worn on her left leg when up in the wheelchair and with any weight bearing activity. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing Home Patient Encounter note for Resident #3 dated 12/26/2024, completed by the MD, revealed .Pt. [patient] continues to have pain & instability of L [left] leg-s/p [status post] tibial fracture. Continues to wear a knee immobilizer . Observation in the dining room on 1/21/2025 at 3:57 PM, revealed Resident #3 was sitting in a wheelchair with an immobilizer brace to her left leg. Resident #3's left leg was notably internally rotated. During an interview on 1/23/2025 at 7:17 AM, the DON stated, [CNA A] had stepped away to help another resident. The DON was asked if CNA A was following the care plan interventions to prevent falls for Resident #3. The DON confirmed CNA A was not following the interventions to prevent a fall. The DON stated, .I did some one-on-one education with [CNA A] . During an interview on 1/23/2025 at 7:19 AM, the MDS Coordinator reviewed the care plan for Resident #3 with the surveyor and verified the fall intervention for staff to remain with the resident, while in the bathroom, was placed on the care plan on 4/15/2024 prior to Resident #3's fall on 8/13/2024. The MDS Coordinator stated the CNAs can review the care plan and the Kardex (a system used to access patient information). The Kardex was reviewed with the MDS Coordinator which also noted for Resident #3, .Staff to remain with resident, while in bathroom . During an interview on 1/23/2025 at 9:53 AM, the Infection Control nurse stated, .we do a quarterly assessment for falls, follow the interventions, and then [the] MDS Coordinator would put it on the care plan . We provided education after the fall .stay with the resident if we place them on the toilet . During an interview on 1/23/2025 at 10:09 AM, CNA C stated, .If I take a resident to the bathroom, I will stay with them, sometimes keep [the] bathroom door cracked to give privacy but watching for residents trying to get up without assistance . 4. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Presence of Right Artificial Knee Joint, Psychotic Disorder with Delusions, Dementia, and Osteoarthritis. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #5 was cognitively intact, received supervision with standing, chair to bed transfers, and walking, and had no falls since the prior assessment. Review of the Morse Fall Scale assessment (Fall Risk Assessment) dated 11/14/2024, revealed, .Category: High Risk for Falling .Score: 90 .Fall Risk is based upon Fall Risk Factors .Determine Fall Risk Factors and Target Interventions to Reduce Fall Risks .Complete on admission, quarterly, at change of condition and after a fall .Has the Resident ever fallen before .Yes .What ambulatory aids if any, does the resident use . Uses furniture for support .GAIT .Impaired .Mental Status .Knows own limits . Review of the facility's Incident Investigation dated 1/2/2025, revealed .Resident [#5] stated that she was sitting on the edge of the bed and began to slide off the side of the bed and landed on buttocks on the floor . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #5's Care Plan dated 1/13/2025, revealed .The resident is at risk for falls .Anti-skid strips to be placed in floor in front of bed .Date Initiated .1/2/2025 . The facility was unable to provide a Fall Risk Assessment for the fall that occurred on 1/2/2025 for Resident #5. 5. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Depression, Urinary Tract Infection, Dementia, Acute Kidney Failure, Diabetes, Adult Failure to Thrive, and Anxiety. Review of the significant change MDS dated [DATE], revealed a BIMS score of 3, which indicated Resident #12 was severely cognitively impaired, required maximum assistance of staff with bed mobility and transfers, used a wheelchair for mobility with assistance of staff, had 2 falls since the prior assessment, and had bed and chair alarms to alert the staff of Resident #12's movements. Review of the facility's Incident Investigation dated 8/19/2024, revealed .Resident [#12] had been propelling self in hallway during this shift and had propelled self into her room. Resident's chair alarm started going off and when the nurse went to check on her resident was sitting on edge of WC [wheelchair] before nurse could assist resident back into WC she suddenly slid off chair landing on right hip area and sustaining a skin tear to right FA [forearm] . Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #12 was severely cognitively impaired, and had behaviors including rejection of care and wandering. Review of the facility's Incident Investigation dated 10/16/2024, revealed .resident [#12] was in dining room after supper .residents' [resident's] [chair] tipped backwards while she was in it . Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated the Resident #12 was severely cognitively impaired, and had wandering behaviors. Review of the Care Plan dated 11/25/2024, revealed .The resident [#12] is at risk for falls .Bed alarm to be placed while resident is in bed. check placement and function each shift .Dycem [a non-slip, non-adhesive material] to be placed in rock and go chair [a wheelchair that is designed to either be used like a regular chair, a tilted back wheelchair, or a rocking chair] at all times . During an interview on 1/21/2025 at 4:11 PM, the DON was asked when a resident falls, when should the care plan be revised. The DON stated, On that day . The facility was unable to provide Fall Risk Assessments for the falls that occurred on 8/19/2024 and 10/16/2024, the readmission on 8/23/2024 and the significant change assessments on 8/30/2024 and 11/21/2024 for Resident #12. 6. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Atherosclerotic Heart Disease, Abnormalities of Gait and Mobility, Muscle Weakness, and Fracture of the Left Pubis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Morse Fall Scale assessment dated [DATE], revealed .Category: High Risk for Falling .Score: 75 .Fall Risk is based upon Fall Risk Factors .Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall . Has the Resident ever fallen before .Yes .GAIT .Impaired .Mental Status .Overestimates or forgets limits . Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #14 was severely cognitively impaired, received maximum assistance from staff for bed mobility, transfers, ambulation and toileting, and used a walker and a wheelchair for mobility. Review of the facility's Incident Investigation dated 12/12/2024 at 2:55 PM, revealed .Heard resident talking in hallway. Checked on resident and noted her sitting in the floor in front of the shower room .Sign on bathroom door stating BATHROOM to cue resident of location of bathroom [initiated 12/12/2024] . Review of the care plan dated 12/16/2024, revealed .The resident [#14] is at risk for falls r/t [related to] history of Fracture, Confusion, Gait/balance problems, Unaware of safety needs .Place sign on bathroom door BATHROOM Date Initiated: 12/12/2024 . The facility was unable to provide a Fall Risk Assessment for the fall on 12/12/2024 for Resident #14. 7. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Dementia, and Hypertension. Review of the facility's Incident Investigation dated 7/26/2024, for Resident #22 revealed, .resident was scooting back in his wheelchair and slide off the edge of the chair . Review of Resident #22's Morse Fall Scale dated 10/13/2024, revealed .Category: High Risk for Falling . Score 75 .Instructions Fall Risk is based upon Fall Risk Factors and it is more than a Total Score. Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall . Review of the significant change MDS assessment dated [DATE], revealed a BIMS score of 2, which indicated Resident #22 was severely cognitively impaired and required maximal assistance with bed mobility and sit to stand. Review of the facility's Incident Investigation dated 12/26/2024, revealed .observed resident [#22] attempting to stand from wheelchair while in the dining room. Resident not fully standing erect, lost his balance and fell to the floor landing on Left shoulder . The facility was unable to provide Fall Risk Assessments for the 7/26/2024 and 12/26/2024 falls for Resident #22. 8. Review of medical record revealed Resident #26 was admitted to the facility on [DATE], with diagnoses including Myocardial Infarction, Fall, Coronary Artery Disease, Diabetes Mellitus, Osteoarthritis, Alzheimer's Disease, and Parkinsonism. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Morse Fall Scale assessment for Resident #26 dated 12/28/2024, revealed .Category: High Risk for Falling .Score: 65 .Fall Risk is based upon Fall Risk Factors .Determine Fall Risk Factors and Target Interventions to Reduce Risks. Complete on admission, quarterly, at change of condition, and after a fall . Has the Resident ever fallen before .Yes .What type of gait does the resident exhibit .Weak .Mental Status . Overestimates and forgets limits . Review of the facility's Incident Investigation dated 1/2/2025 at 12:25 PM, revealed .Social worker was coming through the door when resident [#26] stood up and reached for the wall rail. When resident fell to the floor, he didn't hit his head .No injuries observed at time of incident .Intervention: Staff assist with ambulation as desired during periods of agitation . Review of the care plan dated 1/2/2025, revealed .The resident [#26] is at risk for falls r/t Gait/balance problems, muscular weakness .Ensure resident is wearing appropriate footwear when ambulating in w/c [wheelchair] .Staff to assist resident with ambulation as desired . Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated Resident #26 was moderately cognitively impaired, received maximum assistance of staff for bed mobility, transfer, and toileting, received moderate assistance with ambulating 10 feet, used a wheelchair and walker for mobility, and had 1 fall since prior admission with no injury. Review of the facility's Incident Investigation dated 1/6/2025 at 2:50 PM, revealed .few minutes after leaving the room .heard him [Resident #26] doing something .started falling knocking everything off his table .Skin Tear .Left Elbow .Intervention: Position resident at nurse's station while up and out of bed . Review of the care plan updated on 1/6/2025, revealed: .The resident [#26] is at risk for falls r/t [related to] Gait/balance problems, muscular weakness .Occupational Therapy 5x [times] wk [week] x 30day [30 day] see order for treatment .Physical Therapy 5xwk [5 times a week] x 30days see order for treatment .Position resident at Nurses station while up and out of bed . Review of Progress Note dated 1/9/2025 at 3:55 PM, revealed .Resident [#26] sitting in wheelchair in hall at nurses' desk. Resident attempted to get up and fell in floor .no apparent injuries . Review of the care plan revised on 1/9/2024, revealed .The resident [#26] is at risk for falls r/t Gait/balance problems, muscular weakness . Instruct staff to make sure wheelchair is locked when in use by resident. Also offer an afternoon snack Date Initiated: 1/9/2025 . Review of the facility's Incident Investigation dated 1/11/2025 at 11:16 AM, revealed .At 9 am [9:00 AM] staff seen resident [#26] slide out of the chair .No injuries observed at time of incident .Resident Slid from chair. Intervention: Dycem to w/c to prevent sliding . Review of the care plan revised on 1/11/2025, revealed .The resident [#26] is at risk for falls r/t [related to] Gait/balance problems, muscular weakness .Place dycem in wheelchair . The facility was unable to provide Morse Fall Score assessments for Resident #26's falls on 1/2/2025, 1/6/2025, 1/9/2025, and 1/11/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	9. Review of the medical record revealed Resident #187 was admitted to the facility on [DATE], with diagnoses including Fracture of Left Femur, Fracture Left Radius, Urinary Tract Infection, Dementia, Atrial Fibrillation, and Pacemaker. Review of the Morse Fall Scale dated 11/19/2024, revealed .High risk for falls .Score: 60.0 .Fall Risk is based upon Fall Risk Factors .Determine Fall Risk Factors and Target Interventions to Reduce Fall Risks . Complete on admission, quarterly, at change of condition and after a fall .Has the Resident ever fallen before .Yes .GAIT .Impaired .Mental Status .Overestimates or forgets limits . Review of the care plan dated 11/22/2024, revealed .[Resident #187] is at risk for falls r/t Confusion, Gait/balance problems, Muscular Weakness .Ensure that the resident is wearing appropriate footwear . needs a safe environment with floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, Side rails as ordered, handrails on walls, personal items within reach . Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 10, which indicated Resident #187 was moderately cognitively impaired, received maximum assistance from staff with toileting, transferring and bed mobility, used a wheelchair for mobility and had no falls since admission. Review of the care plan revised on 12/4/2024, revealed .Reclining geri-chair [a wheeled recliner that offers adjustable support and positioning for individuals with mobility challenges] as needed for positioning every shift . Review of the facility's Incident Investigation dated 12/6/2024, revealed .[Resident #187] found kneeling on the floor next to her [Resident #187] bed by CNA .Floor mats added to room r/t decreased safety awareness . Review of the care plan revised on 12/6/2024, revealed .Floor mat to be placed at bedside . The facility was unable to provide a Fall Risk Assessment for Resident #187 for the fall on 12/6/2024. 10. During an interview on 1/23/2025 at 2:00 PM, the Director of Nursing (DON) confirmed the Morse Fall Score assessments are used by the facility to determine a resident's risk for falls and are to be completed on admission, quarterly and at change of condition. The DON was asked should the physician be notified of a change in condition. The DON stated, Yes. The DON was asked if the physician should be notified after a fall. The DON stated, Yes. The DON confirmed a fall is considered a change in condition. During an interview on 1/23/2025 at 3:47 PM, the MDS Coordinator confirmed she does not document actual falls on the care plan. The MDS Coordinator stated, I did but I was told not to. I was told that it wasn't appropriate, that the intervention with the fall date would be the same thing . The MDS Coordinator confirmed that Resident #187 had an intervention of a geri chair for positioning added on to the care plan on 12/4/2024 but did not have a fall on that date. The MDS Coordinator confirmed that interventions are put in place at times when a fall has not occurred and do not necessarily reflect an actual fall has occurred. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	44724 50780

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445372	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hardin County NH	935 Wayne Road Savannah, TN 38372

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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. 46047 Based on facility policy, observations, and interviews, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions when 1 of 6 (Dietary [NAME] B) dietary staff failed to sanitize the thermometer after each use, and when the facility failed to ensure the deep fryer and the cooking stove eyes were clean. The facility had a census of 39 with 39 of those residents receiving a tray from the kitchen. The findings include: Review of the facility's policy titled, Food Preparation Area, dated 5/2013, .Our facility will maintain a clean, sanitary, and safe food preparation area . 1. Observation in the Kitchen on 1/21/2025 at 4:09 PM and 1/23/2025 at 8:28 AM, revealed the deep fryer had dark brown cooking grease with brown crumbs floating on top of the cooking oil and the cooking stove eyes had black build up. 2. Observation in the Kitchen on 1/22/2025 at 10:52 AM, revealed Dietary [NAME] B took the temperature of the broccoli, placed the thermometer into the roast beef and failed to clean the thermometer prior to taking the temperature of the roast beef. Dietary [NAME] B took the temperature of the roast beef bites, the mechanical roast, the puree beans, puree carrots, puree potatoes, baby carrots, diced potatoes, and failed to sanitize with a clean wipe in between each food item. 3. During an interview on 1/23/2025 at 9:46 AM, the CDM was asked what should staff do when taking food temperatures. The CDM stated, . take the alcohol swab and wipe the thermometer off, place the thermometer in the center of the food .remove .each time use a new alcohol pad to wipe off the thermometer before taking temperature of another, the process repeats itself . The CDM was asked when the deep fryer should be cleaned and refilled with clean cooking oil. The CDM stated The deep fryer should be cleaned weekly on Sundays .need to be able to see through the grease or if grease gets dirty need to clean and change the grease . During an interview on 1/23/2025 at 9:59 AM, the CDM confirmed there was black build up on the 6 cooking stove eyes. The CDM confirmed it was carbon build up and the carbon build up should not be on the cooking stove eyes. The CDM stated, .we should have sprayed down and removed the carbon . The CDM confirmed the deep fryer contained brown crumbs and dark brown grease that you could not see through. The CDM stated, .we for sure need to remove the grease and clean the deep fryer .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 30974 Based on review of facility policy, Quarterly Payroll Based Journal (PBJ) review and interview, the facility failed to report PBJ for Quarter 1 of 2024 (October 1, 2024- December 31, 2024). The findings include: 1. Review of the undated facility policy titled, Reporting Direct-Care Staffing Information (Payroll-Based Journal), revealed, .Direct-care staffing and census information will be reported electronically to CMS though the Payroll-Based Journal System (PBJ) system . 2. Review of the Quarterly Payroll Based Journal (PBJ) dated 10/1/2024 - 12/31/2024, revealed, .Failed to Submit Data for the Quarter . During an interview on 1/23/2025 at 3:38 PM, the Administrator confirmed the facility failed to submit the PBJ data, by the required deadline, for the first quarter of 2024.