

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/31/2024
NAME OF PROVIDER OR SUPPLIER  Signature Healthcare of Monteagle Rehab & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 26 Second Street Monteagle, TN 37356	

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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291</b></p> <p>Based on medical record review, observations, and interviews, the facility failed to ensure the call light was within reach and to provide an adaptive call device to meet the need of 1 resident (Resident #41) of 71 residents reviewed for call light accessibility.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #41 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Encephalopathy, Cognitive Communication Deficit, Anxiety, Intellectual Disabilities, and Contractures of the Bilateral Upper and Lower Extremities.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #41 had severe impairment of cognitive skills for daily decision making; was dependent on staff for all Activity of Daily Living (ADL) needs; and had contractures to upper and lower extremities.</p> <p>Review of a comprehensive care plan dated 7/15/2024, revealed .Socially Inappropriate As Evidenced by: Yelling Screaming and crying Related to: Attention seeking .ADLs Functional Status/Rehabilitation Potential . ADL Self Care Deficit r/t [related to] mobility and cognitive deficits &amp; [and] is at risk for complication related to Deficit. Resident needs/requires assist in: All aspects of ADL care .Call light within reach . The resident was monitored and treated by the primary care provider for the yelling, crying, and screaming behaviors.</p> <p>During an observation of Resident #41 in the resident's room on 7/29/2024 at 10:24 AM, revealed the resident was unable to be interviewed due to severe cognitive impairment. The resident was lying in bed with contractures to upper and lower extremities and was yelling out (the resident's usual behaviors). The push button call bell was lying in the floor under the bed and was unavailable for resident use. Due to Resident #41's contractures to bilateral upper extremities, the resident was unable to utilize the push button type of call bell.</p> <p>During an observation of Resident #41 in the resident's room on 7/29/2024 at 12:20 PM, revealed the resident lying in bed with contractures to upper and lower extremities and was yelling out (the resident's usual behaviors). The push button call bell was lying in the floor under the bed and was unavailable for resident use.</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation and interview in Resident #41's room on 7/29/2024 at 12:55 PM, revealed the resident lying in bed with contractures to upper and lower extremities and was yelling out. The push button call bell was lying in the floor under the bed and was unavailable for resident use. The Interim Director of Nursing (IDON) confirmed the call bell was lying in the floor and out of reach of the resident. The IDON and Certified Nursing Assistant (CNA) B both stated Resident #41 was severely contracted and did not have the cognition to utilize the push button call bell. The IDON stated she would have therapy to evaluate Resident #41 for a more suitable call device.</p>		

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<p>F 0584</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 safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45837</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to provide a clean and homelike environment in 3 of 4 shower rooms and 2 residents' rooms (Residents #3 and #74) of 71 residents reviewed for a homelike environment.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights, revised 9/15/2023, revealed .All residents have the right to be treated with respect and dignity .in an environment that promotes .quality of life .</p> <p>During an observation on 7/29/2024 at 12:45 PM, in the [NAME] Shower Room, an observation of the floor revealed 18 missing or broken slate tiles among the floor covering and a dark brown grime on the floor along the baseboard in the corner by the sink.</p> <p>During an interview on 7/29/2024 at 1:00 PM, Certified Nursing Assistant (CNA) C stated the tiles on the floor covering had been broken for an undefined period of time.</p> <p>During an interview on 7/29/2024 at 1:04 PM, CNA D stated tiles on the floor covering had been broken for an undefined period of time.</p> <p>During an observation on 7/29/2024 at 1:09 PM, in the East Shower Room, there were several tiles missing or broken in the floor covering.</p> <p>During an observation on 7/29/2024 at 1:15 PM, in the East Central Shower Room, trash was on the floor, and the shower control cover was missing.</p> <p>During an observation and interview on 7/29/2024 at 1:24 PM, in the East Central Shower Room, Licensed Practical Nurse (LPN) E stated there was trash on the floor and confirmed the East Central Shower Room was not in a clean and homelike condition.</p> <p>During observations and interview on 7/29/2024 at 4:00 PM, the Maintenance Director confirmed that the missing floor tiles in the [NAME] and East shower rooms and the missing shower control cover in the East Shower Room should have been replaced. The Maintenance Director confirmed the shower rooms did not reflect a homelike environment.</p> <p>Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Hypothyroidism, Hypertension, and Down Syndrome.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 7/29/2024 at 8:55 AM, in Resident #3's room, the vinyl on the resident's bathroom floor at the base of the toilet was peeling, had missing pieces, and was noted to have ridged edges. Further observation showed the walls of the resident's room had 2 different colors of paint.</p> <p>During an observation and interview on 7/29/2024 at 4:47 PM, in Resident #3's room, the Maintenance Director confirmed the vinyl on the floor at the base of the toilet was peeling, had missing pieces, and was noted to have ridged edges. The Maintenance Director also confirmed the walls of the resident's room had 2 different colors of paint, and the resident's room did not reflect a homelike environment.</p> <p>49786</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Dementia, Cognitive Communication Deficit, Lack of Coordination, Psychosis, Mood Disorder, and Alzheimer's.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #74 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment.</p> <p>During an observation in Resident #74's room on 7/29/2024 at 11:00 AM, revealed the vinyl flooring around the toilet where the toilet meets the floor was peeling and had missing pieces, of various sizes.</p> <p>During an observation and interview with the Maintenance Director on 7/29/2024 at 4:30 PM, in Resident #74's room, revealed the vinyl flooring around the toilet where the toilet meets the floor was peeling and had missing pieces. The Maintenance Director confirmed Resident #74's room did not represent a homelike environment.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</b></p> <p>Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 residents (Resident #6 and Resident #74) of 26 residents reviewed for abuse. The facility's failure to prevent resident to resident altercations resulted in actual harm for Resident #6. On 6/27/2024, Resident #283 struck Resident #6 with a water pitcher causing a laceration and bruising to the left eye on 12/15/2023 and Resident #74 when Resident #31 struck resident #74 with a walker causing a small cut to Resident #74's right earlobe and a skin tear to the resident's left hand, which resulted in actual HARM to Residents #6 and #74.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 4/14/2022, revealed .organizations intention to prevent the occurrence of abuse .all alleged Abuse, Neglect, exploitation, injuries of unknown origin, and Misappropriation of resident property is investigated .are reported immediately .Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish .</p> <p>Review of the medical record revealed Resident #283 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type, Cognitive Communication Deficit, Unspecified Psychosis, Mood Disorder, and Alzheimer's.</p> <p>Review of a comprehensive care plan for Resident #283 initiated 4/28/2022, revealed .Behavioral .at risk and/or active behavior problems .Physically Aggressive Verbally Aggressive .cursing, hitting and screaming . related to being easily agitated and difficult to redirect .staff will .Provide non-confrontational environment . Anticipate care needs .provide them before the resident becomes overly stressed .Allow resident adequate time to verbalize his feelings .praise him when he verbalizes them in a calm tone .Intervene as needed to protect the rights and safety of others; approach in calm manner, divert attention, remove from situation .take to another location as needed .report changes in behavioral health status to MD [medical doctor] .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #283 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident received antipsychotic and antianxiety medications during the assessment period.</p> <p>Review of the Behavioral Progress Notes for Resident #283 dated 11/9/2023, revealed . Depakote [medication used to stabilize mood] 250 milligrams [mg] TID [three times a day] .Klonopin [medication used to treat anxiety] 1 mg TID .Geodon [medication used to treat Bipolar Disorder] 40mg q [every] AM [morning] and 40mg q PM [night] .judgement poor .insight poor .continue current psych treatment .</p> <p>Review of the Nurse's Progress Notes for Resident #283 dated 11/15/2023, revealed . impatient with poor impulse control and verbal outbursts are common .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the comprehensive care plan for Resident #283 revised 12/15/2023, revealed the resident was involved in a resident to resident altercation. The interventions included .Separate resident immediately to reduce interactions with other resident's [residents] when he is agitated .one on one prn [as needed] .social services as needed .</p> <p>Review of the Social Work Notes for Resident #283 dated 12/15/2023, revealed .SSD [Social Service Director] was notified by DON [Director of Nursing] that a resident to resident [altercation] took place . [Resident #283] .struck .[Resident #6] .in the dining room with a water pitcher .[Resident #283] was sorry for his actions .[Resident #6] .was making inappropriate gestures .order from NP [Nurse Practitioner] to refer [Resident #283] to in-patient psych [psychiatric] related to resident to resident [altercation] .</p> <p>Review of the Nurse's Notes for Resident #283 dated 12/15/2023, revealed .resident [Resident #283] stated to the nurse .[Resident #6] .flipped me off so I hit him with my pink water pitcher . '</p> <p>Review of the facility investigation dated 12/15/2023, revealed a resident-to-resident altercation between Resident #283 and Resident #6 had occurred. A staff nurse was assisting a resident to the dining room. When the staff nurse entered the dining room a resident at the facility informed the nurse Resident #283 hit Resident #6 with a water pitcher. Resident #283 and Resident #6 were immediately separated. Resident #283 had a history of outbursts and aggressive behavior. Resident #283 was placed on 1:1 supervision until the resident was admitted to an inpatient psychiatric facility (admitted to an inpatient psychiatric facility on 12/15/2023 and did not return to the facility). Resident #6 sustained a small laceration/bruise above his left eye. No changes in Resident #6's behavior were observed.</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Dementia, Major Depression, Anxiety, and Schizoaffective Disorder, Bipolar Type.</p> <p>Review of a comprehensive care plan for Resident #6 initiated 3/2/2018 and revised 12/15/2023, revealed . Behavioral .at risk for behaviors identified as verbal aggression, declining care, being short tempered, placing self on floor .staff will .Anticipate care needs and provide them before I become stressed .Monitor behavior to determine underlying cause . Consider location, time of day, persons involved .Provide non-confrontational environment .Refer to Psych NP as needed .Refer to Social Services as needed .Report to Physician any changes in behavioral status .</p> <p>Review of the Behavioral Progress Notes for Resident #6 dated 11/23/2023, revealed . thought process impaired, memory impaired, judgement poor .insight poor .Depakote 500 mg in the morning Remeron [medication used to treat depression] 7.5 mg at bedtime .maintain stabilization .</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 was unable to complete the BIMS assessment, the resident was rarely/never understood, which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident did not receive antipsychotic medications during the assessment period.</p> <p>Review of a comprehensive care plan for Resident #6 revised 12/15/2023, revealed the resident was involved in a Resident-to-resident altercation. The interventions included .Care for abrasion to left eye, per order .Evaluate and monitor for pain and distress .Interview and monitor resident for psychosocial wellbeing .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nurse's Notes for Resident #6 dated 12/15/2023, revealed .resident was involved in an altercation with another resident .[Resident #6] .is pleasant and calm .no s/s [signs and symptoms] of distress .</p> <p>Review of the Nurse's Notes for Resident #6 dated 12/15/2023, revealed .house NP .was notified of resident-to-resident altercation .NP saw resident .new order .Tylenol [medication used to treat pain] 650 mg every 6 hours as needed .for pain .</p> <p>Review of the NP Notes for Resident #6 dated 12/15/2023, revealed .resident involved in a resident-to-resident altercation .small cut .bruise .above .left eye .painful to touch .Tylenol 325mg 2 tabs PO [by mouth] every 6 hours as needed .</p> <p>Review of the Physician's Orders for Resident #6 dated 12/15/2023, revealed .Acetaminophen [Tylenol] .325 mg .2 tabs [tablets] every 6 hours as needed .clean laceration with normal saline and pat dry, monitor s/s of infection .</p> <p>Review of a Skin Integrity Assessment for Resident #6 dated 12/15/2023, revealed .a 2.5 [centimeter (cm)] x [by] 0.1 [cm] x 0 laceration to the resident's left eyebrow with a small amount of blood .first aid applied .</p> <p>During an interview on 7/31/2024 at 9:21 AM, the NP stated Resident #6 was hit in the head with a water pitcher by Resident #283 on 12/15/2023. The NP assessed Resident #6 after the altercation, the resident received a small cut above the left eye with bruising and the resident was ordered Tylenol for pain. The NP confirmed Resident #6 was physically harmed by Resident #283 when he was hit in the head with a water pitcher.</p> <p>Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, Bipolar Disorder, Mood Disorder, Delusions, and Depression.</p> <p>Review of a comprehensive care plan for Resident #31 initiated 12/5/2022, revealed .Behavioral .at risk for behavior problems .screaming and yelling out .easily agitated and sometimes is difficult to re-direct .staff will . Anticipate care needs .provide them before the resident becomes overly stressed .allow him to express how he feels; praise him for any positive communication .</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #31 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident received antipsychotic medications during the assessment period.</p> <p>Review of the Nurse's Note for Resident #31 dated 6/18/2024, revealed .Psych NP rounded today .New orders received .decrease Risperdal [medication used to treat Bipolar Disorder] to 0.25 mg at bedtime .</p> <p>Review of a comprehensive care plan for Resident #31 revised 6/27/2024, revealed the resident was involved in a resident-to-resident altercation. The interventions included .individualized signage on door to identify his room .Psychosocial Follow-up for 72 hours .Separate residents immediately .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Nurse's Notes for Resident #31 dated 6/27/2024, revealed .Resident exhibited aggressive verbal and physical behaviors towards others .placed on [every] 15 minute checks with direct supervision . Psych NP advised to attempt psych placement for increased behaviors .</p> <p>Review of a facility investigation dated 6/27/2024, revealed a resident-to-resident altercation between Resident #31 and Resident #45 had occurred. Certified Nursing Assistant (CNA) I reported to the charge nurse Licensed Practical Nurse (LPN) E she heard loud noises from Resident #74's room. When CNA I entered the room, the CNA observed Resident #31 and Resident #74 arguing. Resident #31 made contact (hit) with Resident #74 using his walker. LPN E was called to the room by CNA I and witnessed CNA I separating the two residents. Resident #74 was observed to have a 1 cm skin tear to his left hand and a 0.5 cm skin tear to the right earlobe. Resident #31 had no injuries, and the residents were immediately separated. Resident #74's injuries were assessed and the wounds to the left hand and right earlobe were treated by LPN E. A psychological evaluation was performed on both residents with no psychological harm identified.</p> <p>Review of the Behavioral Progress Notes for Resident #31 dated 6/30/2024, revealed . memory impaired . judgement poor .insight poor .recent agitation, aggression .Cymbalta [medication used to treat Depression] 60 mg qd [daily] .Risperdal 0.5 mg q AM .0.25mg q hs [bedtime] Depakote 500 mg BID [twice daily] . Remeron 15mg q hs . Resident #31's Risperdal dosage was increased after the altercation (gradual dose reduction (GDR) was ordered on 6/18/2024).</p> <p>Review of the SSD Notes dated 7/1/2024, revealed .[Resident #31] was evaluated after the physical altercation .in no distress, had no concerns and there were no other incidents .</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Dementia, Psychosis, Mood Disorder, and Alzheimer's.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #74 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review showed no behaviors were observed, and the resident received antipsychotic medications during the assessment period.</p> <p>Review of a comprehensive care plan for Resident #74 revised 6/27/2024, revealed .Mood State . Resident . is experiencing disturbed thought processes .secondary to .medical condition .staff will .1:1 visit with social services as needed . Allow resident to express their feelings .Consult with psychiatry/psychology as needed . Encourage and assist to activities .Notify MD with significant changes .resident was involved in a resident-to-resident altercation .Psychosocial Follow-up for 72 hours .Separate residents immediately .</p> <p>Review of the Nurse's Notes for Resident #74 dated 6/27/2024, revealed .No s/s of fear or distress noted .at baseline with emotional status. Resident denies any pain or discomfort .</p> <p>Review of the Physician's Orders for Resident #74 dated 6/27/2024, revealed .clean .skin tear to left hand and right ear lobe .</p> <p>Review of the Interdisciplinary Team (IDT) Notes for Resident #74 dated 6/28/2024, revealed, .IDT met and reviewed .Resident is often confused and has periods of agitation .reviewed and discussed recent interactions with others .no s/s of distress .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the SSD Notes for Resident #74 dated 7/1/2024, revealed . SSD followed up with resident . regarding the incident that occurred on Friday [6/27/2024] with .[Resident #31] .Resident stated that he is fine and no issues or concerns with the incident .stated .no other incidents have occurred with the .[Resident #31] .</p> <p>During an interview on 7/30/2024 at 9:00 AM, CNA I stated she witnessed the resident-to-resident altercation between Resident #31 and #74 on 6/27/2024. CNA I was walking down the hallway and heard what sounded like a .scuffle . coming from Resident #74's room. When the CNA entered the room Resident #31 had entered Resident #74's room, Resident #74 was exiting the bathroom, Resident #74 told Resident #31 to leave his room, and Resident #31 hit Resident #74 with his walker which resulted in an injury to the right ear lobe. CNA I immediately intervened and had Resident #31 put the walker down. When Resident #31 lowered the walker, Resident #74 hit Resident #31, and the walker caused a skin tear to Resident #74's left hand. LPN E was notified of the incident, and the LPN treated the injuries to Resident #74's left hand and right ear. CNA I removed Resident #31 from Resident #74's room, neither resident remembered the altercation when asked about it later in the shift, and no other behaviors were observed. CNA I also stated she had not observed Resident #31 in any altercations since the 6/27/2024 incident.</p> <p>During an interview on 7/30/2024 at 2:49 PM, LPN E stated she was working when the resident-to-resident altercation occurred between Resident #31 and Resident #74 on 6/27/2024. LPN E stated she was familiar with Resident #31 and Resident #74. The LPN was called to Resident #74's room by CNA I. CNA I informed the LPN Resident #31 had entered Resident #74's room. Resident #74 was coming out of the bathroom and saw Resident #31 in the room and told Resident #31 to leave. Resident #31 lifted his walker and hit Resident #74, scratching Resident #74's right earlobe before the CNA could stop him. Resident #74 attempted to punch Resident #31 to protect himself and hit the walker causing the skin tear to Resident #74's left hand. LPN E stated Resident #31 gets confused about what room is his and he entered Resident #74's room unintentionally. When the LPN entered Resident #74's room, CNA I had separated the residents. Both residents were assessed by LPN E, Resident #74 received a minor scratch on his right earlobe, there was a Scant amount . of blood. The earlobe was cleansed, and no further treatment was required. Resident #74 received a skin tear to the left hand , the hand was cleansed and required 2 steri-strips (wound closure tape). Resident #31 sustained no injuries and was taken back to his room immediately by CNA I and placed on 1:1 supervision for 72 hours. Both residents were monitored closely after the incident and 15 minutes after the altercation, neither resident could recall the incident. LPN E stated Resident #31 was usually easy to redirect when he had behaviors. Resident #31 had a GDR of Risperdal in June 2024 prior to the altercation .this might have caused the incident . LPN E stated Resident #31's Risperdal was increased back to the original dosage, and the resident had not had any further altercations or incidents.</p> <p>During an interview on 7/30/2024 at 3:11 PM, LPN F stated she was the Behavioral Health Nurse at the facility and was familiar with Resident #31. LPN F stated Resident #31 had a GDR of the Risperdal in June 2024, several days prior to the 6/27/2024 altercation between Resident #31 and Resident #74. LPN F did not witness the incident, but recalled Resident #74 received a minor injury to his earlobe. Resident #31's Risperdal was increased back to the original dosage, and the resident had not had any further altercations since the 6/27/2024 incident.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Signature Healthcare of Monteagle Rehab & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE 26 Second Street Monteagle, TN 37356	
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F 0600  Level of Harm - Actual harm  Residents Affected - Few	During an interview on 7/31/2023 at 5:40 PM, the Interim Director of Nursing (IDON) stated she was not employed at the facility when the altercation took place between Residents #283 and #6. The IDON reviewed the medical record for Residents #283 and #6 and confirmed Resident #6 received an injury when Resident #283 hit the resident in the head with a water pitcher. Further interview revealed the IDON was not employed at the facility when the altercation took place between Residents #31 and #74. The IDON reviewed the medical record for Residents #31 and #74 and confirmed Resident #74 received an injury when Resident #31 hit the resident with the walker.		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50480</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to develop a comprehensive person-centered care plan related to Post Traumatic Stress Disorder (PTSD) for 2 residents (Resident #61 and Resident #78) of 4 residents reviewed for PTSD.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plans, revised 2/9/2024, revealed .The facility will develop and implement a comprehensive person-centered care plan for each resident .to meet resident's . mental and psychosocial needs that are identified in the comprehensive assessment .</p> <p>Review of the medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including Schizophrenia, Convulsions, Anxiety, Depression, and PTSD.</p> <p>Review of a comprehensive care plan dated 10/1/2021, revealed Resident #61 did not have a person-centered care plan developed for PTSD.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #61 was rarely/never understood which indicated the resident had severe cognitive impairment and had an active diagnosis of PTSD.</p> <p>Review of the Nurse Practitioner's (NP) Note for Resident #61 dated 7/1/2024, revealed the resident had an active diagnosis of PTSD and had an active treatment regimen in place.</p> <p>49792</p> <p>Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including Schizophrenia, Anxiety, Bipolar, Epilepsy, and PTSD.</p> <p>Review of a comprehensive care plan dated 5/28/2024, revealed Resident #78 did not have a person-centered care plan developed for PTSD.</p> <p>Review of the NP's Note for Resident #78 dated 5/29/2024, revealed the resident had an active diagnosis of PTSD and had an active treatment regimen in place.</p> <p>Review of a 5-day admission MDS assessment dated [DATE], revealed Resident #78 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and the resident had an active diagnosis of PTSD.</p> <p>During an interview on 7/31/2024 at 2:30 PM, the Social Services Director (SSD) confirmed Resident #61 and Resident #78 had an active diagnosis of PTSD and confirmed a person-centered care plan for PTSD was not developed for Resident #61 and Resident #78.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786</b></p> <p>Based on medical record review, observation, and interviews, the facility failed to follow a physician's order for 1 resident (Residents #74) of 6 residents reviewed for weight loss.</p> <p>The findings include:</p> <p>Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Cognitive Communication Deficit, Lack of Coordination, and Alzheimer's Dementia.</p> <p>Review of a comprehensive care plan for Resident #74 dated 9/14/2023, revealed .Resident at risk for alteration in nutritional .status r/t [related to] Dx's [diagnoses] Dementia .CHF [Congestive Heart Failure] . mood d/o [disorder] .provide diet as ordered .</p> <p>Review of the medical record revealed Resident #74's weights were as follows: 2/5/2024 189.5, 3/5/2024 169.0, 4/17/2024 169.0, 5/14/2024 171.0, 6/10/2024 172.2, and 7/23/2024 168.4. The residents weights are stable and the resident did not have wounds.</p> <p>Review of the Registered Dietician (RD) Notes for Resident #74 dated 5/15/2024, revealed .Resident weighs 170# [pounds] Weight is - [minus] 0.6% [percent] x [times] 30, -10% x90 and -8% x 180 days. Stable again this month. Diet is Regular. No supplements .Eating 75% .</p> <p>Review of the Physician's Order for Resident #74 dated 6/4/2024, revealed .Regular diet .double protein portions at all meals .</p> <p>Review of the Nurse's Notes dated dated 6/4/2024, revealed .RD add double protein portions to all meals .</p> <p>Review of the Dietary Note for Resident #74 dated 6/5/2024, revealed .Regular diet .gets double portions .</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #74 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment.</p> <p>Review of the Nurse's Notes dated 7/25/2024, revealed .reviewed resident's weight. Resident current weight is 168.4 which is up 0.5 % from last week .</p> <p>During an interview on 7/30/2024 at 12:00 PM, Licensed Practical Nurse (LPN) H stated Resident #74 was prescribed double portions .not long ago . and his (Resident #74) weights have stabilized.</p> <p>During an interview on 7/30/2024 at 12:10 PM, Certified Nursing Assistant (CNA) G stated she routinely cared for Resident #74 and was familiar with his care. CNA G stated Resident #74 did not receive double protein portions with meals, the resident feeds himself, the resident had a good appetite, and consumed 75-100% of the meals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview and observation in the dining room on 7/30/2024 at 12:17 PM, LPN E stated she was familiar with Resident #74. LPN E stated if Resident #74 received double protein portions at meals, it would be documented on the resident's meal ticket (information dietary staff use to ensure proper diet orders for the residents). LPN E observed Resident #74's meal and confirmed the resident did not receive double protein portions for lunch. Further observation of Resident #74's meal ticket revealed the ordered double protein portions were not documented on the meal ticket. Resident #74 was eating independently with no identified concerns.</p> <p>During an interview on 7/30/2024 at 12:00 PM, the Lead Dietician stated Resident #74 had a dietary assessment on 6/5/2024 that recommended double protein portions. The Lead Dietician reviewed Resident #74's meal tickets and confirmed the double protein portions were not documented on the meal tickets.</p> <p>During an interview on 7/31/2024 at 12:10 PM, the Dietary Manager stated the information for double protein portions for Resident #74 was not communicated to the dietary department.</p> <p>During an interview on 7/31/2024 at 1:40 PM, the Director of Regulatory stated resident nutrition orders are input in the facility's resident documentation program, and the orders are communicated to the Meal Tracker (program dietary uses for meals). The Director of Regulatory stated the provider's order for double protein portions for all meals for Resident #74 was sent to the dietary department on 6/4/2024 at 6:10 AM. Further interview revealed the Dietary Manager submitted the double protein portions information for the lunch meal ticket but failed to submit double protein portions for breakfast and dinner tickets. The Director of Regulatory confirmed Resident #74 had an order for double protein portions for all meals but the information had not been inputted correctly to reflect the order on the meal tickets.</p>

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>45837</p> <p>Based on facility policy review, observation and interviews, the facility failed to post accurate daily staffing information for 7 days of 1 of 1 days observed for staff posting.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Posting of Nurse Staffing, revised 5/13/2024, revealed .The facility will post the daily staffing on a daily basis .Facility name .The current date .The total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift .registered nurses .licensed practical nurses .certified nurse aides .Resident census .The facility will post the nurse staffing data .at the beginning of each shift .</p> <p>During an observation on 7/29/2024 at 8:00 AM, the daily staff posting revealed a date of 7/22/2024.</p> <p>During an interview on 7/31/2024 at 2:00 PM, the Interim Director of Nursing stated it was her expectation nurse staffing would be posted daily.</p> <p>During an interview on 7/31/2024 at 2:25 PM, Licensed Practical Nurse (LPN) F stated she was responsible to post nurse staff posting daily. LPN F confirmed the daily staff posting on 7/29/2024 was dated 7/22/2024, and it had not been updated for 7 days to reflect current nursing staff in the facility .it fell through the cracks .</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48100</p> <p>Based on facility policy review, observations, and interviews the facility failed to maintain kitchen equipment in a sanitary condition and failed to discard expired food which had the potential to affect 71 of 71 residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Food: Preparation, dated ,d+[DATE], revealed .food contact equipment . will be cleaned and sanitized after every use .</p> <p>During an observation and interview with the Dietary Manager (DM) on [DATE] at 8:42 AM, in the food preparation area, revealed the food processor had dried white food debris present to the inner bowl, in multiple areas. The DM stated the white substance was probably bread and was unsure when the food processor was last used.</p> <p>During an observation and interview with the DM on [DATE] at 8:47 AM, in the walk-in refrigerator area, revealed one 5-pound container of cottage cheese, ,d+[DATE] full, with an expiration date of [DATE]. The DM stated the cottage cheese was used to prepare lasagna (date unknown) and was only used during cooking.</p> <p>During an interview on [DATE] at 8:50 AM, the DM confirmed the expired container of cottage cheese was available for resident use and should have been discarded, and the food processor was not maintained in a sanitary condition.</p>

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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>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50407</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to post signage at the facility entrance to alert visitors of the current confirmed SARS-Co-V-2 (Covid-19) outbreak after Resident #17 tested positive for Covid-19 on 7/29/2024 which had the potential to affect 71 of 71 residents.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (Covid-19) Pandemic, updated 3/18/2024, revealed . Establish a process to identify .confirmed .SARS-CoV-2 infection .post .signs .at the entrance .to provide guidance .</p> <p>Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Respiratory Failure, Morbid Obesity, Chronic Venous Stasis Ulcers, and Schizophrenia.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #17 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Review of the Nurse's Notes for Resident #17 dated 7/29/2024, revealed .Resident complained of sore throat .NP [Nurse Practitioner] notified, and new order received for Covid test .Resident placed on droplet precautions .</p> <p>Review of the Covid-19 Test for Resident #17 dated 7/29/2024, revealed .Results .Positive .</p> <p>During an observation on 7/29/2024 at 9:54 AM, Resident #17 had an Isolation Droplet Precaution sign on her door.</p> <p>Review of a comprehensive care plan dated 7/29/2024, revealed Resident #17 had an .Active Infection . Covid 19 . care plan.</p> <p>During an observation on 7/29/2024 at 4:40 PM and on 7/30/2024 at 7:48 AM, revealed there was no posted signage at the facility entrance to reflect the current confirmed Covid-19 outbreak.</p> <p>During an interview on 7/30/2024 at 8:12 AM, Infection Preventionist (IP) Licensed Practical Nurse (LPN) A stated when residents tested positive for Covid-19, the residents were placed on Isolation Precautions. IP LPN A further stated she was not aware to post signage at the facility entrance to alert visitors of the confirmed Covid-19 outbreak.</p> <p>During an interview on 7/31/2024 at 3:17 PM, IP LPN A confirmed the facility failed to post signage on 7/29/2024 at the facility entrance to alert visitors of the current confirmed Covid-19 outbreak.</p>		