STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445401	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Northbrooke	121 Physicians Dr Jackson, TN 38305

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 38909 Based on policy review, observation, and interview, the facility failed to ensure staff maintained residents' dignity and respect when 2 of 13 staff members (Certified Nursing Assistant (CNA) A and CNA B) failed to knock and announce themselves before entering a resident's room during dining and during a random observation. The findings include: Review of the facility's Promoting/Maintaining Resident Dignity Policy, dated 11/20/2023 revealed, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity . Explain .before initiating the activity .Respect the resident's living space . Observation during the Hall 200 dining on 5/20/2024 at 11:30 AM, revealed CNA A entered Resident #14's room and failed to knock or announce themself before entering resident's room. Observation during the Hall 200 dining on 5/20/2024 at 11:33 AM, revealed CNA A entered Resident #71's room and failed to knock or announce themself before entering the resident's room. Observation during the Hall 200 dining on 5/20/2024 at 11:38 AM, revealed CNA A entered Resident #66's room and failed to knock or announce themself before entering the resident's room. Observation during the Hall 200 dining on 5/20/2024 at 11:40 AM, revealed CNA A entered Resident #23's room and failed to knock or announce themself before entering the resident's room. Observation on the 200 Hall on 5/20/2024 beginnins at 12:14 PM, revealed the following: a. CNA B failed to knock or announce self before entering Resident # 58's room. b. CNA B failed to knock or announce self before entering Resident # 18's room. c. CNA B failed to knock or announce self before entering Resident # 32's room. d. CNA B failed to knock or announce self before entering Resident # 52's room. (continued on next page)

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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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. CNA B failed to knock or announce self before entering Resident # 3's room. f. CNA #B failed to knock or announce self before entering Resident # 14's room. g. CNA B failed to knock or announce self before entering Resident # 71's room. h. CNA B failed to knock or announce self before entering Resident # 56's room. i. CNA B failed to knock or announce self before entering Resident # 66's room. During an interview on 5/23/2024 at 3:21 pm, the Interim Director of Nursing (DON) confirmed that staff should knock and announce before entering the resident's room. The facility staff failed to ensure staff maintained residents' dignity and respect when they did not knock and announce themselves before entering a residents' room.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 48285 Based on policy review, observation, and interview, the facility failed to provide effective housekeeping to maintain a sanitary environment for 10 of 59 resident rooms (Resident #7, #12, #26, #28, #41, #43, #51, #52, #66, #189). The findings include: 1. Review of the facility's policy titled Resident Rights and Resident Responsibilities, dated 11/20/2023, revealed .The resident has the right to a safe, clean, comfortable Homelike environment . 2. Observation in the resident's room on 5/20/2024 at 8:14 AM, revealed Resident #12's room had a strong urine odor, dirty gloves, and towels on the floor in the bathroom. 3. Observation in the resident's room on 5/20/2024 at 8:16 AM, revealed Resident #26's bathroom had an odor of urine and urine in toilet, dried brown liquid substance on the toilet seat, and a bath basin in the bathroom with a brush and several unlabeled supplies in it. 4. Observation in the resident's room on 5/20/2024 at 8:21 AM, revealed Resident #51's wall beside the bed had been scraped and had white dust and debris on the floor, the bathroom floor revealed 2 unlabeled and uncovered bath basins. 5. Observation in the resident's room on 5/20/2024 at 8:36 AM, revealed Resident #7's floor with crumbs debris, the bathroom floor had a used toothbrush, 2 unlabeled and uncovered bath basins, an empty bottle, and an unlabeled deodorant on the sink. 6. Observation in the resident's room on 5/20/2024 at 8:45 AM, revealed that Resident #28's bathroom had a strong odor of urine, urine and brown substance in the toilet, and a dirty towel and wash cloth in the floor. 7. Observation in the resident's room on 5/20/2024 at 11:26 AM and 5/23/2024 at 9:25 AM, revealed Resident #52's privacy curtain had a large brown stain. 8. During an observation and interview in the resident's room on 5/20/2024 at 12:24 PM, revealed Resident #41's bathroom revealed a yellow barrel containing soiled linen with a strong foul odor. CNA A was asked if the barrel should be in Resident #4's bathroom CNA A stated No. 9. Observation in the resident's room on 5/21/2024 at 7:40 AM, 5/23/24 at 2:16 PM, 5/24/24 at 8:35 AM and 5/28/24 at 11:21 AM, revealed Resident #43 had an unlabeled and uncovered bed pan and basin in the bathroom floor. 10. Observation in the resident's room on 5/21/2024 at 11:22 AM, 5/21/24, 5/22/2024 at 7:31 AM and 5/28/24 at 11:28 AM revealed Resident #189's had an unlabeled and uncovered bedpan and basin in the bathroom floor. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11. Observation in the resident's room on 5/22/24 at 8:30 AM, revealed Resident #189 had an unlabeled and uncovered bed pan, and basin noted in the bathroom floor. The overflowing bathroom garbage can contained soiled briefs with foul urine odors. 12. During an interview on 5/22/2024 at 9:01 AM, the Interim Director of Nursing (DON) confirmed nothing dirty should be in the resident's room including dirty towels, it should be placed in a bag and out in the linen barrel for laundry. 13. Observation in the resident's room on 5/22/2024 at 11:41 AM and 5/23/2024 at 9:31 AM, revealed Resident #66's privacy curtain had a large dark brown stain on the bottom of the curtain and several brownish orange stains. 14. During an interview on 5/23/2024 at 3:21 PM, the Interim DON confirmed dirty linen, dirty incontinent bed pads should not be on the floor in resident rooms, dirty incontinent briefs should be placed in plastic bag and taken to a garbage barrel outside of the resident room, resident wash basins should clean, in a plastic bag and not left in the floor, privacy curtains should be clean, toilets should be clean and flushed after each use, resident rooms should clean without odors, the residents floors should be clean, and no dirty linen barrels should be placed in a resident's bathroom.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review, review of the ADL (Activities of Daily Living) Verification Worksheets, Night shift shower assignment sheet, and interview, the facility failed to ensure Activities of Daily Living (ADL) assistance related to bathing and showering was provided for 3 of 20 (Resident #31, #35 and #74) sampled residents reviewed for ADL care. The findings include: 1. Review of the facility policy titled, Activities of Daily Living (ADL), dated 4/17/2024, revealed, .A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good . grooming and personal and oral hygiene . Review of the facility undated policy titled, AHC Resident Rights and Responsibilities, revealed, .Respect and dignity, recognizing each resident's individuality, wishes and preferences . 2. Review of the medical record revealed Resident #35 was admitted to the facility on [DATE], with diagnoses of Hemiplegia, Cerebral Infarction, Ataxia, Epilepsy, Depression, Arthritis, Muscle Weakness, Anxiety, and Depression. Review of the Care Plan dated 9/1/2022, revealed, .Self care deficit R/T [related to] ambulation, bathing, bed mobility, dressing, eating, hygiene, locomotion and transfers .will be assisted with ADLs as required Bathing . Shower .3xweek .alternating days with bed baths .Prefers shave every other day . Review of the quarterly MDS dated [DATE], revealed resident had a BIMS score of 6 which indicated he was severely cognitively impaired and need substantial/maximal assistance for all ADL's. Review of the Nightshift shower assignment sheet revealed Resident #35 was to receive a shower on Monday, Wednesday and Friday. Review of the facility ADL Verification Worksheet for March, April and May 2024 revealed Resident #35 did not receive a shower on 3/1/2024, 3/4/2024, 3/6/2024, 3/8/2024, 3/11/2024, 3/13/2024, 3/15/2024, 3/18/2024, 3/20/2024, 3/22/20024, 3/25/2024, 3/27/2024, 3/29/2024, 4/1/2024, 4/3/2024, 4/5/2024, 4/8/2024, 4/10/2024, 4/12/2024, 4/15/2024, 4/19/2024, 4/22/2024, 4/24/2024, 2/26/2024, 4/29/2024, 5/1/2024, 5/3/2024, 5/6/2024, 5/8/2024, 5/10/2024, 5/13/2024, 5/15/2024, 5/17/2024 and 5/20/2024. 3. Review of medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses of Polyarthritis, Osteoarthritis, and Dementia. Review of the Care Plan dated 10/17/2023, revealed Resident #31 .will be assisted with ADLs .Bath/ [and, or] Shower .3x [times] week/prn .alternating days with bed baths . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #31 had a Brief Interview for Metal Status (BIMS) score of 15, which indicated she was cognitively intact and required physical help for most ADLs. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nightshift shower assignment sheet revealed Resident #31 was to receive a shower on Tuesday, Thursday and Saturday. Review of the facility ADL Verification Worksheet for March, April, and May 2024, revealed Resident #31 did not receive showers on 3/2/2024, 3/5/2024, 3/7/2024, 3/9/2024, 3/12/2024, 3/14/2024, 3/16/2024, 3/19/2024, 3/21/2024, 3/23/2024, 3/26/2024, 3/28/2024, 3/30/2024, 4/2/2024, 4/4/2024, 4/6/2024, 4/9/2024, 4/11/2024, 4/13/2024, 4/15/2024, 4/18/2024, 4/20/2024, 4/23/2024, 4/25/2024, 4/27/2024, 4/30/2024, 5/2/2024, 5/4/2024, 5/7/2024, 5/14/2024, 5/16/2024 and 5/18/2024. 4. Review of the medical record revealed Resident #74 was admitted to the facility on [DATE], with diagnoses of Hemiplegia, Diabetes, Cerebrovascular Disease, Edema, and Morbid Obesity. Review of the Care Plan dated 1/20/2024, revealed, .Self care deficit R/T ambulation, bathing, bed mobility, dressing, eating, hygiene, locomotion and transfers . Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated she was cognitively intact, had impairments of upper and lower extremities on one side, required set up assist with meals, and substantial/maximal assist with other ADLs including bathing/showering. Review of the facility shower schedule revealed Resident #74 should have showers 3 times weekly. Review of the facility ADL Verification Worksheets for March, April and May 2024 revealed Resident #74 did not receive showers as scheduled on 3/9/2024, 3/12/2024, 3/142024, 3/16/2024, 3/19/2024, 3/23/2024, 3/26/2024, 3/28/2024, 3/30/2024, 4/2/24, 4/4/2024, 4/11/2024, 4/18/2024, 4/20/2024, 4/25/4/30, 4/27/2024, 5/2/2024, 5/11/2024, 5/17/2024, 5/20/2024, and 5/22/2024. 5. During an interview on 05/23/24 at 10:12 AM, the Interim Director of Nursing (DON) was asked the process of showers, she stated, .On admission showers are assigned by bed, then residents are asked their preference day or night. All residents get 3 showers a week . During an observation and interview on 5/24/2024 at 11:22 AM, the Interim DON was shown the ADL Verification Worksheet with the missing dates of showers. The Interim DON was asked should residents have their showers per schedule and preference. The Interim DON stated Yes .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33379 Based on policy review, medical record review, observation, and interview the facility failed to provide necessary treatment and services to promote the healing of a pressure ulcer wound for 2 of 4 sampled residents (Resident #73 and #189) reviewed for pressure ulcers. The facility failed to provide ordered wound care and failed to ensure a pressure reducing mattress was properly implemented. The findings include: 1. Review of the facility's policy titled, Pressure Injury Prevention and Non-Pressure Ulcer Management dated February 26, 2024, revealed .It is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure ulcers/injury present, and to promote wound healing of various types of wounds in accordance with current standards of practice and Physician orders .Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence .A pressure injury will present as intact skin or an open ulcer .The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear .The facility shall establish and utilize a systemic approach for pressure injury prevention and management .starting with prompt assessment and treatment .reduce and remove underlying risk factors, monitor the impact of the interventions .Evidenced-based interventions for prevention shall be implemented for all residents .Provide appropriate pressure redistributing, support surfaces including mattresses A pressure reducing mattress shall be placed on all beds .Evidence-based treatments in accordance with current standards of practice shall be provided for all residents who have pressure injury . Review of the eMaxAir Pro Mattress manufacturer's guidance revealed .System features .for alternating pressure therapy, the eMax Air Pro surface should be used in combination with the control unit . 2. Review of the medical record revealed Resident #73 was admitted on [DATE], with diagnoses of Quadriplegia, Cerebral infarction, Hypertension, and Pressure Ulcer of Sacral Region and Hip. Review of the care plan dated 11/13/2023 revealed .Nursing - Wound Care and Management . 11/10/23 [11/10/2023]- Sacrum- Present on Admission . 1/01/24 [1/1/2024]- Stage 2 Right hip, present upon readmission . Assess and monitor wound healing .Assess and monitor wound treatment plan for effectiveness and complications .wound care as ordered . Review of the admission Minimum Data Set (MDS) dated [DATE], revealed rarely/never understood, severely impaired decision making, impaired movement of bilateral upper and lower extremities, dependent on staff for Activities of Daily Living (ADLs), incontinent of bowel and bladder, 1 stage 2 pressure ulcer, present on admission, a pressure reducing device for the bed, surgical wound care, pressure ulcer/injury care, application of nonsurgical dressings and applications of ointment/medications. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the January 2024 Treatment Administration Record (TAR) revealed . Santyl [an ointment used to remove damaged tissue from chronic skin ulcers] 250 unit/[per]gram topical ointment .One Time Daily Starting 01/09/2024 .sacrum .Clean area with Normal Saline. Apply Santyl and calcium alginate [a gelling fiber dressing for moderate to highly draining wounds] for autolytic debridement, cover with boarder gauze and cover with border gauze . The treatment to the sacral wound was not signed as being administered on 1/12/2024, 1/16/2024, and 1/19/2024. Review of the January 2024 TAR revealed .Santyl .Every One Day Starting 01/09/2024 .Clean right hip with normal saline, apply Santyl 250 unit/gram topical ointment and xeroform [a petroleum- based gauze dressing that maintains a moist wound environment] for autolytic debridement. cover with boarder gauze . The treatment to the Right hip was not signed as being administered on 1/12/2024, 1/16/2024, and 1/19/2024. During an interview on 5/28/2024 at 6:25 PM, the Regional Nurse Consultant confirmed the treatments were not signed out on 1/12/2024, 1/16/2024 and 1/19/2024 and that treatments should have been signed out if the have been completed. During an interview on 5/29/2024 at 1:32 PM, the Administrator was asked do you expect treatments to be done as ordered. The Administrator stated, Yes. 3. Review of the medical record revealed that Resident #189 was admitted to the facility on [DATE], with Pressure Ulcer Stage IV of sacral region, Malnutrition, Dementia, and Cerebrovascular Accident. Review of the admission MDS dated [DATE], revealed severe cognitive impairment, required maximum assistance with all ADL's (Activities Daily of Living), always incontinent of bowel and bladder, and 1 stage 4 pressure ulcer that was present on admission. Review of the Care Plan dated 5/20/2024 revealed .admitted with pressure ulcer on sacrum, At risk for further skin breakdown .5/15/24--stg [stage] 4 to sacrum with negative pressure wound therapy .Pressure ulcer will show signs of healing and be free of infection .Observe for changes in pressure ulcer .Pressure reducing mattress .Reduce pressure to affected area .Treatment as ordered, monitor and report if ineffective . Wound vac [a wound vacuum device removes the pressure over the area of the wound] /treatments as ordered .receiving wound vac therapy to sacral wound .assess wound for dimension appearance, increase drainage, odor or pain wound to be assessed per facility protocol alternate dressing if vac therapy is interrupted and notify md/np [Medical Doctor/Nurse Practitioner] .wound vac to be changed as ordered . Review of the Physician's Orders dated 5/20/2024, revealed Negative Pressure Wound Therapy 2 Times Weekly .Notes: Clean sacrum with Normal Saline, Apply Drape to peri wound, apply oil emulsion [nonadherent petroleum based gauze] contact layer if needed, apply foam, cover drape and attach [NAME] pad [a track pad with suction tubing connects to a wound vacuum canister], apply Negative pressure wound therapy at 125mm/HG [millimeters of mercury], document number of foam pieces used in the wound bed. Review of the May 2024 TAR showed the treatment was not signed as being administered on 5/24/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 5/28/2024 at 4:17 PM, LPN (Licensed Practical Nurse) J described Resident #189's current sacral wound's condition and visual undermining noted with serosanguinous drainage, bone present, wound appearance beefy red wound bed. Resident was observed with a pro air mattress not attached to an air unit. LPN J was asked if the resident was on an air mattress. LPN J stated, No, but [resident] should be. During an interview on 5/29/2024 at 10:51 AM the Interim Director of Nursing (DON) was shown Resident #189's Treatment Administration Record regarding wound care for May. The interim DON was asked to interpret the meaning of =(equal) sign on 5/24/2024 for the scheduled wound care. The interim DON stated that it meant previously scheduled and that it could reflect a duplication in documentation. The Interim DON stated that she could not tell if care was done or not. Interim DON stated that the resident's nurse would be able to inform if the care was performed or not. The interim DON was asked if the care is ordered and performed should it be completed on the Medication Administration Record (MAR) and Treatment Administration Record (TAR). The Interim DON confirmed that the TAR should reflect all care performed by all staff. The Interim DON was asked if a resident is admitted and is care planned for a pressure reducing mattress, should it be implemented. The Interim DON confirmed that it should be implemented if it is ordered, and care planned for the resident. The Interim DON was asked who is responsible for implementing air mattress. The Interim DON stated that the maintenance director is responsible for putting it on the resident's bed and the nurse is responsible for putting the work order in. The Interim DON stated that the nurse is responsible for ensuring that the mattress is provided for the resident. During an interview on 5/29/2024 at 11:40 AM, the Interim DON reported that LPN K was the nurse that was assigned to Resident #189 on 5/24/24 and would have been responsible for performing the scheduled wound care on 5/24/2024. During an interview on 5/29/24 at 12:41 PM, LPN K was asked if she was assigned to take care of Resident #189 on 5/24/24. LPN K confirmed that she was assigned Resident #189 on 5/24/2024. LPN K was asked if she performed the scheduled wound care treatment for resident on that day. LPN K stated, No, I didn't because I ran out of time, and I left it for the night shift to do. During an interview on 5/29/24 at 1:14 PM, the Administrator was asked if wound care is performed on a resident how should it be documented to reflect it was done. The Administrator stated that the staff should sign off on the resident's MAR/TAR. The Administrator was asked if the resident is care planned for a pressure reducing mattress what mattress should be used for the resident. The Administrator confirmed that residents that have stage 3 or 4 pressure ulcers should have air mattresses. The Administrator was asked if wound care should be performed as ordered. The Administrator stated, Yes. The facility failed to provide ordered wound care and failed to ensure pressure reducing mattress was properly implemented.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909 Based on policy review, medical record review, observation, and interview, the facility failed to ensure staff was following physician orders for a Percutaneous Gastrostomy (PEG) tube feeding and failed to date and label PEG tube feedings for 2 of 2 (Resident #43 and #73) sampled residents reviewed for enteral feedings. The findings include: 1. Review of the facility's policy titled Tube Feeding Management/Restore Eating Skills dated 5/26/2023, revealed .Feeding tube care and services shall be provided in accordance with resident needs and professional standards of practice .Continuous feedings is the uninterrupted administration of enteral formula over brief extended periods of time .Gastrostomy tube is a tube that is placed directly into the stomach through the abdominal wall incision for administration of food, fluids, and medications. The most common type is a percutaneous endoscopic gastrostomy [PEG] tube .Document the formula, rate, med flushes, auto flushes, and how administered . 2. Review of the medical record revealed that Resident #43 was admitted to the facility on [DATE], with diagnoses of Stroke, Diabetes, Aphasia, Seizure, and Malnutrition. Review of the physician's orders revealed Glucerna 1.5 CAL [Calorie] 70 milliliters per hour [ML/HR] with 55 cubic centimeter per hour [cc/hr] autoflush continuous effective 2/13/2024. Review of the quarterly MDS (Minimum Data Set) dated 4/23/2024, revealed Resident #43 with a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately cognitively impaired. Resident required maximum assistance of staff with Activities of Daily Living (ADLs) with toileting, bathing, dressing, and transferring. Resident was assessed for feeding tube. Observation in resident's room on 5/20/2024 at 4:10 PM Resident #43 with enteral feeding infusing at 70ml/hr and feeding bag not labeled with formula. Enteral bag labeled with 5/20/24 @ 0500 hrs (hours) T.P with approximately 200ml in bag. Water flush bag noted without a label with approximately 50ml in bag, and pump set for water flush to administer 55ml every hour. Observation in the resident's room on 5/21/2024 at 7:40 AM, revealed resident with enteral feeding infusing at 70ml/hr with flush 55ml/hr per pump. Feeding bag and flush bag not labeled with type of formula and rate of administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During and observation and interview on 5/21/2024 at 2:13 PM with Staff N added 500 ml of Glucerna 1.5 from an opened container to Resident #43's hanging enteral feeding bag at bedside. Staff N was asked how she knew what was in the resident's hanging enteral bag. Staff N stated it was Glucerna 1.5 and should have been labeled by the morning nurse. Staff N took a black sharpie marker out of her pocket and wrote Glucerna 1.5 500 ml on the enteral feeding bag and refilled the water flush bag. Staff N was asked, if the bag should have been labeled by the nurse that hung it this morning. The Staff N stated, Yes, it should have. The Staff N was asked how the next shift nursing staff was supposed to know when she had added the 500ml of Glucerna 1.5 to the feeding bag. The Staff N confirmed that she needed to go back into the resident's room and add the time to the feeding bag. Observation in the resident's room on 5/23/2024 at 7:45 AM, revealed resident with enteral feeding infusing at 70ml/hr with water flush 55ml/ every hour per pump. The feeding bag was not labeled with the formula rate and the flush bag was not labeled at all. Observation in the resident's room on 5/29/2024 at 10:01 AM revealed resident with enteral feeding infusing at 70ml/hr and water flush at 55ml/hr per pump. Water flush bag not labeled. Feeding bag labeled with resident name, Glucerna, date 5/28, and no time noted. 3. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] with diagnosis of Traumatic Subdural Hemorrhage, Quadriplegia, Gastrostomy Status, Tracheostomy status, Acute Respiratory Failure with Hypoxia, and Pressure Ulcer of the Sacral Region. Review of a Physician's Order dated 5/21/2024 revised on 5/24/2024, revealed .Jevity 1.5 @ [symbol for at] 65 ml/hr [milliliters] hr [hour] w [with] 45 ml/hr h2o [water]flush . Observation in Residents 73's room on 5/22/2024 at 7:31 AM, and 4:32 PM, 5/24/2024 at 8:31 AM, and 10:29 AM, revealed Jevity infusing at 55ml/hr with H20 water infusing at 100 ml every 4 hours, and the enteral feeding bag and water bag were undated and unlabeled. During an observation and interview in resident's room on 5/24/2024 at 11:14 AM, the Interim Director of Nursing (DON) confirmed the feeding rate was incorrect at 55 ml/hr and the water hanging rate of 100 ml/hr was incorrect. Confirmed the feeding and water bags were not dated or labeled. Interim DON at this time changed the Jevity rate to 65 ml/hr and the water rate to 45 ml/hr via pump machine as per order. The Interim DON confirmed the feeding and water rates should be infusing as ordered, and also should be dated and labeled.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 48285 Based on policy review, observations and interviews, the facility failed to ensure all licensed nurses independently demonstrated competency while providing care and services for 2 of 6 Nurses (Licensed Practical Nurse (LPN) L and LPN O) observed. The findings include: Review of the facility's policy titled Medication Administration dated 8/4/2023, revealed .Medications shall be administered by licensed .nursing personnel acting within the scope of practice . Review of the facility's policy titled Tube Feeding Management/Restore Eating Skills dated 5/26/2023, revealed Purpose .To ensure that staff providing care and services to the resident via [by] feeding tube are aware of, competent in and utilize facility protocols regarding .care. Observation during Medication Administration on 5/21/2024 at 7:25 AM, revealed LPN L had cleaned the glucometer by wiping it 1 time with a Sani wipe and set it on the medication cart when another nurse that identified herself as a Regional Nurse (Assistant Director of Nursing) coached LPN L by telling her to wipe the meter 3 times with the Sani cloth .LPN L knocked on Resident #20's door and the Regional Nurse coached LPN L to wash her hands as she entered the room. Observation during Medication Administration on 5/21/2024 at 11:30 AM, revealed LPN O was administering a medication by Percutaneous Endoscopic Gastrostomy (PEG) Tube. LPN O was having difficulty with the medication being administered per gravity and asked the Unit Manager, that was present in the room what she should do. The Unit Manager coached LPN O to apply light pressure to syringe. During an interview on 05/29/2024 at 11:22 AM, The Assistant [NAME] President (AVP) of Clinical Operations, was asked if coaching is common practice for the nurses. The AVP of Clinical Operations stated, I reminded the nurses that there should be no coaching . I asked the AVP of Clinical Operations if there should there have been a nurse coaching while I was observing, she stated There is no policy that says they can't talk or ask questions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 38909 Based on policy review, observation, and interview, the facility failed to store all drugs and biologicals in locked compartments when a medication cart was left unlocked and unattended for 1 of 7 medication storage areas (Medication Cart 1) and when medications were left at the resident's bedside for 1 of 23 sampled resident's rooms (Resident #19). The findings include: 1. Review of the facility ' s policy titled, Medication Administration: Medication, Controlled and Biological Storage, Night/Emergency Box and Backup Pharmacy, dated 9/5/2023, revealed .It is the policy of this facility to ensure all medications housed on our premises shall be stored in the pharmacy and/or medication rooms .All drugs and biologicals shall be stored in locked compartments .Only authorized personnel shall have access .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart . 2. Observation in Resident #19's room on 5/20/2024 at 8:48 AM, revealed Latanoprost Ophthalmic eye drops (used to treat high pressure inside the eye due to glaucoma) on the nightstand. During an interview on 5/20/2024 at 8:56 AM, the Interim DON confirmed that medication should not be at the bedside. During an observation and interview outside of Resident #51's room on 5/24/2024 at 8:31 AM, revealed that Medication Cart 1 was left unlocked and unattended. LPN (Licensed Practical Nurse) H was coming out of the room when she was asked if she should leave the medication cart unlocked and unattended. LPN H stated, No, I shouldn't have left it unlocked . During an observation and interview outside of Resident #73's room on 5/24/2024 at 8:43 AM, revealed LPN H left Medication Cart 1 unlocked as she was going into Resident #73's room to administer medications. LPN H was asked as she was coming out of Resident #73's room, if she should leave the medication cart unlocked. LPN H stated, No. During an interview on 5/28/2024 at 3:30 PM, the Interim DON (Director of Nursing) was asked if the medication carts should be left unlocked, unsecured, and unattended. The DON stated, No. The facility failed to ensure that all drugs and biologicals used in the facility were stored in locked compartments.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, observation, and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by carbon build-up on the cooking stove, unlabeled and undated food items, and expired food items. The facility had a census of 88 with 84 of those residents receiving a tray from the Kitchen. The findings include: 1. Review of the Dietary: Food Storage, revealed .To provide guidance on how food is to be stored .All store items should have an expiration date .A 'Use-By' date is the last date recommended for the use of the product while at peak quality . ' Open Date ' -refrigerated .food .prepared and packaged .shall be clearly marked at the time the original container is opened . 2. Observation in the Kitchen on [DATE] at 11:46 AM, revealed an opened, undated package of tater tots, undated hamburger patties and undated hashbrowns. 3. Observation in the Kitchen on [DATE] at 4:14 PM, revealed the cooking stove burners had a black-build-up on the right back eye and the right front eye, a large cooking skillet with carbon build-up hanging from the metal hook, opened, undated tater tots, and undated hashbrowns. 4. A random observation in room [ROOM NUMBER] on [DATE] at 8:03 AM revealed 2 cartons of Vitamin D milk cartons with an expiration date of [DATE]. During an interview on [DATE] at 8:03 AM, Resident #48 stated, That milk is sour, look at that date, I can't drink that . During an interview on [DATE] at 8:04 AM, Resident #64 confirmed he had already drunk his milk and stated, It didn't taste good. During an interview on [DATE] at 8:16 AM, CNA I was asked if the breakfast trays she delivered this morning had expired milk on the tray. CNA I stated, .yes I had 2 residents with spoiled milk that was dated [DATE], Resident #20 had milk that was chunky when she poured into a bowl over her cereal. Resident #65 had soured milk with a date of [DATE] as well. CNA I was asked if she told anyone about the expired sour milk. CNA I stated, .no I didn't tell anyone, but I did get them both another carton of milk that wasn't expired . During an interview on [DATE] at 8:10 AM, the Certified Dietary Manager (CDM) was asked should the facility be serving expired milk. The CDM stated, No. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 8:23 AM, Dietary Aide F was asked where he obtained the milk cartons from for this morning. Dietary Aide F stated, I grabbed a bin of milk from the refrigerator and put the milk on the trays. I ran out and had to get another bin of milk and put what was in there on the meal trays. Dietary Aide F was asked if he checked the expiration date before putting the milk on the meal tray. Dietary Aide F stated, No, I figured since they were in there, they [milk] were good 5. Observation in the Kitchen on [DATE] at 2:30 PM, revealed the cooking stove burners had a black-build-up on the right back eye and the right front eye, a large cooking skillet with carbon build-up hanging from the metal hook. During an interview on [DATE] 2:30 PM, the Certified Dietary Manager (CDM) confirmed the cooking stove should not have a build-up of a black substance on the two eyes. The CDM confirmed the large skillet had a build-up of carbon on it. The CDM stated, .I have to get a new skillet, it should not be like that . The CDM was asked the risk of the carbon build up. The CDM stated, .Could cause a grease fire . The CDM confirmed that expired milk should not be served to the residents, and the tater tots and hashbrowns should be dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46047 Based on policy review, observation, and interview, the facility failed to ensure food was served under sanitary conditions when 3 of 13 staff members (Certified Nurse Aide (CNA) A and B and Licensed Practical Nurse (LPN) C) failed to perform proper hand hygiene during meal service and the facility failed to ensure precautions were followed to prevent spread of infections, failed to handle and store linens to prevent the spread of infection, and failed to ensure hygiene procedures were followed by staff when 4 of 4 staff members (Housekeeper D, Certified Nurse Assistant (CNA) A, and Licensed Practical Nurse (LPN) E and O) did not wear personal protective equipment (PPE) in a resident's room, when CNA A placed a dirty incontinent brief and a dirty incontinent pad on the resident's floor, and when CNA A and LPN E failed to perform hand hygiene. The findings include: 1. Review of the facility's policy titled, Hand Hygiene, dated 3/28/2024 revealed .Staff involved in direct resident contact shall perform proper hand hygiene procedures to prevent the spread of infection .Hand hygiene is indicated and shall be performed under the conditions listed .Hand Hygiene Table .Between resident contacts . Before applying and after removing personal protective equipment (PPE) including gloves . Before and after handling clean or soiled dressing, linens .After handling potentially contaminated objects . Review of the facility's policy dated 11/1/2017, titled, Transmission Based Precautions, revealed, .To provide guidance on taking appropriate precautions to prevent transmissions of infectious agents .Enhanced Barrier Precautions .An order for enhanced barrier precautions shall be obtained for residents with any of the following .tracheostomy .Make gowns and gloves available .PPE for enhance barrier precautions .when performing high-contact care activities .include .changing linen, changing briefs .device care or use . tracheostomy/ventilator tubes . Review of the facility's policy titled, Hand Hygiene, dated 3/28/2024 revealed .Staff involved in direct resident contact shall perform proper hand hygiene procedures to prevent the spread of infection .Hand hygiene is indicated and shall be performed under the conditions listed .Hand Hygiene Table .Between resident contacts . Before applying and after removing personal protective equipment (PPE) including gloves . Before and after handling clean or soiled dressing, linens .After handling potentially contaminated objects . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation in the Resident #42's room on 5/20/2024 at 10:25 AM, revealed an enhanced barrier signage on Resident #42's door and no isolation cart on the 200 Hall. CNA A had no gown on while providing incontinent care for Resident #42. There was a dirty brief on the floor and a dirty incontinent pad on the floor. CNA A finished the incontinent care for the resident, picked up the dirty incontinent brief off the floor and placed it in the trash, picked up the dirty incontinent pad off the floor and put it in a yellow-colored soiled linen bin in the hallway, returned to the resident's room, and failed to remove the gloves and perform hand hygiene. With the same gloved hands on, CNA A grabbed and pulled the resident's incontinent pad and with the help of Housekeeper D, repositioned Resident #42. CNA A touched Resident #42's enteral feeding machine with the same gloved hands. CNA A did not remove the gloves and perform hand hygiene before she touched the enteral feeding machine to turn it back on. CNA A picked up items off the adjacent bed, placed them in a clear trash bag, threw them away, removed her gloves, and did not perform a hand hygiene. Observation during the Hall 200 dining on 5/20/2024 at 11:23 AM, revealed CNA A did not perform hand hygiene before removing a meal tray from the meal cart, entered Resident #30's room with the meal tray, placed the meal tray on the resident's over the bed table, removed the lid from the meal tray, used her hands to pull the resident's privacy curtain back, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:26 AM, revealed CNA A did not perform hand hygiene before removing a meal tray from the meal cart, entered Resident #52's room with the meal tray, placed the meal tray on the resident's over the bed table, removed the lid off the meal tray, used her hands to move the over the bed table, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:27 AM, revealed CNA A did not perform hand hygiene before getting a meal tray from the meal cart, entered Resident #3's room with the meal tray, placed the meal tray on the over the bed table, picked up a white towel and placed it in the resident's wheelchair, used her hands to move the over the bed table, and did not perform hand hygiene. CNA A removed the utensils from the napkin, removed the paper from the straw and placed the straw in the drink, picked up the towel and put it in a container in the hall, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:30 AM, revealed CNA A did not perform hand hygiene before getting a meal tray from the meal cart, entered Resident #14's room with the meal tray, placed the meal tray on the over the bed table, picked up the bed remote to bring the head of the bed higher, and did not perform hand hygiene. CNA A pulled the paper off the straw and placed the straw in the drink, removed the utensils from napkin, gave a wipe to the resident for the resident to wash her hands, took the wipe from the resident and placed the wipe in the trash, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:33 AM, CNA A did not perform hand hygiene before getting a meal tray from the meal cart, entered Resident #71's room with the meal tray and placed the meal tray on the resident's bed. Then CNA entered Resident #41's room with the meal tray, placed the meal tray on the over the bed table, moved the resident's wheelchair with her hands, and did not perform hand hygiene. CNA A removed the utensils from the napkin, removed the paper from the straw, placed the straw in the drink, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation during the Hall 200 dining on 5/20/2024 at 11:36 AM, CNA A did not perform hand hygiene before the getting a meal tray from the meal cart, entered Resident #56's room with the meal tray, placed the meal tray on the over the bed table, and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:38 AM, revealed CNA A did not perform hand hygiene before she got a meal tray from the meal cart, entered Resident #66's room with the meal tray, placed the meal tray on the over the bed table, picked up the resident's bed remote to adjust the head, and did not perform hand hygiene. CNA A removed the utensils from the napkin, removed the paper from the straw, placed the straw in the drink, left the room and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation during the Hall 200 dining on 5/20/2024 at 11:40 AM, revealed CNA A did not perform hand hygiene before she got a meal tray from the meal cart, entered Resident #23's with the meal tray, placed the meal tray on the over the bed table, removed the utensils from the napkin, removed the paper from the straw, placed the straw in the drink, left the room and did not perform hand hygiene before she removed the next resident's meal tray from the meal cart. Observation in the dining room on 5/20/2024 at 11:45 AM, revealed CNA A did not perform hand hygiene before getting a meal tray out of the meal cart, placed the meal tray in front of Resident #45, removed the utensils from the napkin, removed the paper from the straw, placed the straw in the drink, did not perform hand hygiene and immediately went to Resident #70, picked up her utensils, cut up her food, and did not perform hand hygiene when she finished. Observation in the dining room on 5/20/2024 at 11:50 AM, revealed CNA A used her hands to touch her hair, did not perform hand hygiene before removing a meal tray from the meal cart, placed the meal tray in front of Resident #9, removed the utensils from the napkin, removed the paper from the straw, placed the straw in the resident's drink, did not perform hand hygiene, removed another meal tray from the meal cart, confirmed it was Resident #29's meal tray and left the dining room with the meal tray. 3. Observation in the dining room on 5/20/2024 at 11:53 AM, Licensed Practical Nurse (LPN) C used her hands to lift up a lid on a trash can, did not perform hand hygiene, removed a meal tray from the meal cart, placed the meal tray in front of Resident #36, removed the utensils from the napkin, removed the paper from the straw, placed the straw in the drink, did not perform hand hygiene, accepted another meal tray from a kitchen staff and placed it in the meal tray in the cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an interview on 5/21/2024 at 10:30 AM, CNA A was asked about entering Resident #42's room being that there was an enhanced barrier precautions signage on the door. CNA A stated, I did not see the sign, normally a cart is by the resident's door with gowns, gloves, and masks in it. I know the signage tells us what we need to do before entering the room. CNA A was asked should she have had the gown on when she provided incontinent care for the Resident #42. CNA A stated, Yes. CNA A was asked whenever incontinent care is provided what is the proper procedure for handling a dirty brief once it is removed from the resident. CNA A stated, I really do not know what the procedure is here, but where I have worked in the past you could take the soiled barrel in the room with you, but not here. CNA A was asked should a dirty incontinent brief and a dirty incontinent pad be placed on the floor. CNA A stated, It should not be on the floor, should have a trash bag to place the dirty brief in and the incontinent pad should not be on the floor linen, it should have been placed in a barrel but, not on floor. CNA A was asked to tell about hand sanitization after finishing incontinent care. CNA A stated, You should wash hands with soap and water if hands are soiled and if not soiled can use hand sanitizer. CNA A was asked should she have removed your gloves and performed hand hygiene before she touched the enteral feeding machine to turn the resident's feeding back on. CNA A stated, Yes. During an interview on 5/21/2024 at 10:38 AM, Housekeeper D was asked about enhance barrier precautions. Housekeeper D stated, This is the first time seeing enhanced barrier precautions. I usually see droplet precautions. I am wondering what enhanced barrier precautions is for. Housekeeper D confirmed the signage on the Resident #42's door tells what needs to put on before entering the resident's room. Housekeeper D was asked did she wear personal protective equipment (PPE) before entering Resident #42's room to help reposition the resident. Housekeeper D stated, No, it supposed to be stuff sitting outside the resident's room for us to put on. Observation on 5/21/2024 11:56 AM, revealed Licensed Practical Nurse E for the 200 Hall entered Resident #42's room with no PPE on. There is no isolation cart on the hall. LPN #E placed a patch on left side of neck with no gown on, removed gloves and put them in the trash and did not perform hand hygiene. Observation in Resident #42's room on 5/22/24 08:11 AM, revealed a dirty white towel with a yellow substance sitting on top of a compressor [the machine used to deliver humidity to the tracheostomy]. During an observation and interview in Resident #42's room on 5/22/2024 at 8:46 AM, LPN #E was asked should the dirty white towel with the yellow substance be sitting on top of the compressor [the machine used to deliver humidity to the tracheostomy]. LPN E stated, I guess they left it [the dirty white towel]. I am guessing it [yellow substance on the white towel] is whatever she [the resident] threw up last night. LPN E stated, It [the dirty white towel with yellow substance on it] should not be there,. 5. During an interview in the Interim Director of Nurses' (DON) office on 5/22/2024 at 9:01 AM the Interim DON was asked a should a dirty towel with a yellow substance be in the resident's room on the machine that delivers humidity. The Interim DON stated, No, not anything dirty should be in the residents including dirty towels, it should be placed in a bag and out in the linen barrel for laundry. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445401	A. Building B. Wing	05/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Northbrooke	121 Physicians Dr Jackson, TN 38305

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Observation in Resident #186's room on 5/23/24 at 8:08 AM revealed LPN O at bedside performing an accu-check and administering medications without PPE on. Resident with an enhanced barrier sign on her door. 7. During an interview on 5/23/2024 at 3:21 PM, the Interim Director of Nurses (DON) was asked should staff throw a soiled incontinent bed pad on the floor. The Interim DON stated, No, soiled linen should not be on floor, it [soiled linen] should be placed in a plastic bag and placed in a soiled linen barrel. The Interim DON was asked should staff throw a dirty incontinent brief on the floor. The Interim DON stated, No, incontinent briefs should be placed in plastic bag and taken to the garbage barrel outside of the resident room. The Interim DON was asked to tell about enhanced barrier precautions signage and what staff should do before entering the room. The Interim DON stated, It tells what to do before they enter, they should wear mask, gown, and gloves and they should be wearing gloves and gown for any extended period of time. The Interim DON confirmed staff should wear gown and gloves while providing incontinent care for a resident who is on enhanced barrier precautions and while providing care near the resident's tracheostomy for a resident who is on enhanced barrier precautions. The Interim DON confirmed during meal tray delivery and set up, staff should perform hand hygiene before removing meal trays from the meal cart and after each meal tray delivery. The Interim DON confirmed during meal tray delivery and set up, staff should perform hand hygiene after touching the furniture, the equipment, the resident, and the linen. During an interview on 5/24/2024 at 10:10 AM the Interim DON was asked what it means when a resident is in enhanced barrier precaution. The Interim DON confirmed that all staff must wear gown and gloves when touching the resident.