

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445401	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2025
NAME OF PROVIDER OR SUPPLIER Northbrooke Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Physicians Dr Jackson, TN 38305	

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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow resident to participate in the development and implementation of his or her person-centered plan of care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure Care Plan conference meetings were held at least quarterly for 3 of 25 (Resident #4, #17 and #28) sampled residents reviewed for care plan meetings.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility policy titled Resident Participation - Care Plan, dated 2021, revealed .Spouses and other members of the family may participate in the development of the person-centered care plan with the resident's permission .The care planning process: facilitates the inclusion of the resident and /or representative .holding care planning meetings at times of day when the resident, representative and family members can attend and are functioning at their best .The social services director or designee is responsible for notifying the resident/representative and for maintaining records . Review of the medical record review revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Osteomyelitis, Chronic Obstructive Pulmonary Disease, and Methicillin Resistant Staphylococcus Aureus Infection. <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #4 was cognitively intact.</p> <p>Review of the Interdisciplinary Team Care Plan Review dated 7/2/2024 revealed Resident #4 nor his representative was invited to the Care Plan meeting after the completion of the 3/19/2025 MDS assessment.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #4 was cognitively intact.</p> <p>Review of the Interdisciplinary Team Care Plan Review dated 10/9/2024, revealed Resident #4 nor his representative was invited to the Care Plan meeting after the completion of the 10/1/2024 MDS assessment.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #4 was cognitively intact.</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 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Interdisciplinary Team Care Plan Review dated 1/2/2025, revealed Resident #4 nor his representative was invited to the Care Plan meeting after the completion of the 1/2/2025 MDS assessment.</p> <p>During an interview on 4/13/2025 at 3:06 PM, Resident #4 was asked if he participates in the Care Plan meetings, Resident #4 stated, I don't know what that is, and have never been to one</p> <p>During an interview on 4/14/2025 at 3:06 PM, the Regional MDS, confirmed Care Plan meetings should be completed on admission and quarterly, and Resident #4 nor his representative was present for the care plan meetings on 7/2/2024, 10/9/2024 and 1/2/2025.</p> <p>3. Review of the medical record revealed Resident # 17 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Heart Failure, and Osteoarthritis.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident # 17 was cognitively intact.</p> <p>Review of the Interdisciplinary Team (IDT) Care Plan Review dated 12/20/2024, revealed no documentation that the resident or representative was invited or attended the care plan meeting.</p> <p>During an interview 4/13/2025 at 12:28 PM, the resident confirmed that she was not aware of any care plan meetings.</p> <p>During an interview on 4/15/2025 at 10:20 AM, the SW confirmed that the MDS Coordinator or SW are responsible for inviting the residents to the Care Plan Meetings. SW confirmed that the meeting notes and IDT Care Plan Review should reflect all who attended and the resident's signature if she attended.</p> <p>4. Review of the medical record review revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Cerebrovascular Disease with Hemiplegia, Dementia, Morbid Obesity, Pseudobulbar Affect, Anxiety, and Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #28 was cognitively intact.</p> <p>Review of the Interdisciplinary Team Care Plan Review dated 10/19/2024, revealed Resident #28 nor her representative was invited to the Care Plan meeting after the completion of the 9/16/2024 MDS assessment.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #28 was cognitively intact.</p> <p>Review of the Interdisciplinary Team Care Plan Review dated 12/30/2024, revealed Resident #28 nor her representative was invited to the Care Plan meeting after the completion of the 12/17/2024 MDS assessment.</p> <p>Review of the annual MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated Resident #28 was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0553</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility is unable to provide the Interdisciplinary Team Care Plan Review meeting for the 3/17/2025 MDS assessment.</p> <p>During an interview on 04/13/2025 at 12:39 PM, Resident #28 was asked if she participates in the Care Plan process and attend the meetings. Resident #28 stated, I don't think I have been to a care plan meeting.</p> <p>During an interview on 4/15/2025 at 10:17 AM, the Regional MDS was asked how often the resident and/or family should be invited to a Care Plan meeting. The Regional MDS stated, .on admission, annually, and quarterly . The Regional MDS confirmed the IDT (Interdisciplinary Team) had not had a Care Plan meeting in March 2025 after the completion of the 3/17/2025 MDS assessment.</p> <p>49269</p> <p>50408</p>		

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<p>F 0567</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 manage his or her financial affairs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47127</p> <p>Based on the facility policy, Patient Trust record review and interview the facility failed to assure residents who have authorized the facility in writing to manage any personal funds have ready and reasonable access to those funds for 2 of 19 (Resident #35 and #51) sampled residents reviewed for personal funds.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the policy titled Links Healthcare Resident Trust Policy, dated 1/1/2019 revealed the facility will . maintain a resident trust fund for residents who desire to participate .To establish a policy and procedure that will ensure the integrity of the resident funds received at the facility through safeguards and accurate records of resident funds with verification through a reconciliation process .Petty cash .Upon request from resident or authorized representative to withdraw funds .The funds will be given directly to the resident or authorized representative within a reasonable time period of the request . 2. Review of medical records revealed Resident #35 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Metabolic Encephalopathy and Major Depressive Disorder. <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview Mental Status (BIMS) score of 14, which indicated Resident #35 was cognitively intact.</p> <ol style="list-style-type: none"> 3. Review of medical records revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Diabetes, Anxiety Disorder and Chronic Diastolic Congestive Heart Failure. <p>Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #51 was cognitively intact.</p> <ol style="list-style-type: none"> 4. During a Resident Council Meeting in the activity room on 4/15/2025 at 2:00 PM, 17 Residents were asked whether they had access to resident funds during after-hours and on weekends and residents responded no. Two residents (Resident #35 and Resident #51) verbalized they were not able to access their accounts at night and on the weekend and would like to have access to their funds. <p>During an interview on 4/15/2025 at 4:30 PM, the Account Receivable (AR) Consultant stated the receptionist would be responsible for dispensing cash to the residents after hours and on the weekends. When asked if they currently have a receptionist that would be responsible, she stated, the facility is working on a plan to get money available for the residents during the nights and weekends. The facility was currently working on the dynamics of getting the funds available because they are aware of the regulations.</p> <p>Review of Resident Fund Management Service Statements revealed that both Resident #35 and Resident #51 have funds available.</p>		

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<p>F 0569</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269</p> <p>Based on policy review, medical record review, withdrawal record review, and interview, the facility failed to refund 3 of 3 (Resident #329, #330, and #331) resident's account balances within 30 days of death.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy .Resident Trust Policy, dated 1/1/2019, revealed .The facility will surrender all resident trust funds of the resident or authorized representative within three (3) normal banking days upon discharge of the resident or within thirty (30) days upon the death of a resident. 2. Review of the medical record revealed Resident #329 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Pressure Ulcer, Vascular Dementia, and Depression. <p>Review of Nurse's Note dated 3/4/2025, revealed Funeral director arrived and removed body from room .</p> <p>Review of the facility's Withdrawal Record dated 4/15/2025, revealed a refund for the amount of \$25.40 was processed for resident's family on 4/15/2025.</p> <ol style="list-style-type: none"> 3. Review of the medical record revealed Resident #330 was admitted to the facility on [DATE], with diagnoses including Kidney Failure, Sepsis, Parkinson's Disease, and Hemiplegia. <p>Review of Nurse's Note dated 2/15/2025, revealed .this nurse assessed resident, vs [vital signs] unable to be obtained, contacted hospice services to notify of change in condition, nurse arrived at approx [approximately] 0330 [3:30 AM] .funeral home arrived and retrieved resident .</p> <p>Review of the facility's Withdrawal Record dated 4/15/2025, revealed a refund for the amount of \$772.89 was processed for the Resident's estate on 4/15/2025.</p> <ol style="list-style-type: none"> 4. Review of the medical record revealed Resident #331 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, and Dysphagia. <p>Review of the Nurse's Note dated 1/26/2025, revealed .The DON [Director of Nursing] pronounce the death time at 1658 [4:58 PM] .</p> <p>Review of the facility's Withdrawal Record dated 4/15/2025, revealed a refund for the amount of \$1,617.29 was processed for the Resident's estate on 4/15/2025.</p> <ol style="list-style-type: none"> 5. During an interview on 4/15/2025 at 4:16 PM, the Accounts Receivable staff confirmed that the resident's account balances were refunded late. 		

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<p>F 0578</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 request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on policy review, record review, and interview, the facility failed to provide information to the residents regarding their right to formulate an advance directive for 13 of 25 (Residents #4, #11, #17, #27, #30, #34, #37, #49, #61, #62, #278, #279, and #478) residents reviewed for advance directives.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled Advance Directives, dated September 2022, revealed .The resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy .Advance Directive-a written instruction, such as a living will or durable power of attorney for health care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when the individual is capacitated .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative .</p> <p>2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Osteomyelitis Left Ankle and Foot, Chronic Obstructive Pulmonary Disease, Hepatic Encephalopathy, and Methicillin Resistant Staphylococcus Aureus Infection.</p> <p>Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated cognitively intact.</p> <p>There was no documentation in the medical record if Resident #4 had an Advance Directive or if the Resident would like to formulate an Advance Directive.</p> <p>3. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Gastrotomy, Dementia, and Cerebral Infraction, and Dysphagia.</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #11 had a BIMS score of 3, which indicated severe cognitive impairment.</p> <p>The facility was unable to provide completed documentation that the resident representative was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>4. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Heart Failure, and Osteoarthritis.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #17 was cognitively intact.</p> <p>The facility was unable to provide written documentation or education for formulating Advance Directive was provided to the resident.</p> <p>5. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Peripheral Vascular Disease, Osteomyelitis Left Ankle and Foot, Chronic Kidney Disease Stage 4, Left Below Knee Amputation and Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #27 had a BIMS score of 15, which indicated cognitively intact.</p> <p>The facility was unable to provide written documentation or education for formulating Advance Directive was provided to the resident.</p> <p>6. Review of the medical record revealed Resident #30, was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Acute Pulmonary Edema, and Acute/Chronic Respiratory Failure.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #30 has severe cognitive impairment.</p> <p>The facility was unable to provide completed documentation that the resident representative was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>7. Review of the medical record review revealed Resident #34 was admitted to the facility on [DATE], with diagnoses including Covid-19, Senile Degeneration, Vascular Dementia, and Diabetes.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #34 had a BIMS score of 9, which indicated moderate cognitive impairment.</p> <p>The facility was unable to provide completed documentation that the resident representative was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>8. Review of the medical record revealed Resident #37 was admitted to the facility on [DATE], with diagnoses including Depression, and Cerebral Infraction, Hemiplegia and Hemiparesis.</p> <p>Review of the admission MDS assessment dated [DATE] revealed Resident #37 had a BIMS score of 7, which indicated severe cognitive impairment.</p> <p>The facility was unable to provide completed documentation that the resident representative was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>9. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Sepsis, Candidal Stomatitis, Dyspnea, Fracture of Left Pubis, Venous Insufficiency, and Dementia.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No MDS completed at this time.</p> <p>The facility was unable to provide completed documentation that the resident representative was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>10. Review of the medical record revealed Resident #61 was admitted to the facility on [DATE], with diagnoses including Gastrostomy, Dysphagia, and Parkinson's Disease.</p> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #61 had a BIMS score of 14, which indicated intact cognition.</p> <p>The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>11. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction with Hemiplegia, Diabetes, Morbid Obesity, and Depression.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed Resident #62 has a BIMS score of 15, which indicated cognitively intact.</p> <p>The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>12. Review of the medical record revealed Resident #278 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes, and Peripheral Vascular Disease.</p> <p>No MDS completed at this time.</p> <p>The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>13. Review of medical records revealed Resident #279 was admitted to the facility on [DATE], with diagnoses including Inflammatory Disorder of Scrotum, Acute Respiratory Failure and Diabetes.</p> <p>No MDS completed at this time.</p> <p>The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>14. Review of the medical record revealed Resident #478, was admitted to the facility on [DATE], with diagnoses including, Chronic Kidney Disease Stage 3, Chronic Pain, Gastrointestinal Hemorrhage, and Chronic Obstructive Pulmonary Disease.</p> <p>No MDS completed at this time.</p> <p>The facility was unable to provide completed documentation that the resident was educated regarding advanced directives and/or to formulate an advance directive.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>15. During an interview on 4/15/2025 at 10:45 AM, with the Administrator in Training (AIT) and the Social Worker, in the Social Service office, was shown the advance directives given. AIT and SW confirmed that the forms provided are incomplete of information needed for advance directives. They are unable to provide what education was provided or resident or family members initials signatures also if resident was offered or declined or assisted with advance directives.</p> <p>46047</p> <p>47127</p> <p>49269</p> <p>50408</p> <p>51740</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47127</p> <p>Based on policy review, medical record review, observations and interview the facility failed to obtain a Physician's Orders for foley catheter care for 1 of 25 (Resident #6) sampled residents reviewed for urinary catheter care and failed to follow physician orders for 1 of 25 (Resident #63) sampled residents, and</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the policy titled Enhanced Barrier Precautions dated August 2022, revealed Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBPs remain in place for the duration of the resident's stay or until resolution of the wound and/or indwelling medical devices regardless of MDROs colonization. 2. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Severe Protein-Calorie Malnutrition, Diabetes, Gastrostomy, Anxiety, Brief Psychotic Disorder, and Alzheimer's Disease. <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #63 was severely cognitively impaired. Resident was dependent for bed mobility, transfers, eating, and toileting.</p> <p>Review of the Care Plan dated 2/21/2025, revealed a focus for depression, pain, psychotropic medications, and hypothyroidism.</p> <p>Review of the Physician Order dated 6/26/2024, revealed .LEVOTHYROXIN TAB 25MCG [microgram] Give 1 tablet orally in the morning related to HYPOTHYROIDISM .</p> <p>Review of the Physician Order dated 9/6/2024, revealed .DIVALPROEX CAP 125MG [milligram] .Give 4 capsule orally in the morning .And Give 2 capsule orally two times a day related to BRIEF PSYCHOTIC DISORDER .</p> <p>Review of the Physician order dated 9/20/2025, revealed .INSULIN ASPART 100UNIT/ML [milliliters] SOLN [solution] Inject as per sliding scale .intramuscularly before meals and a bedtime related to TYPE 2 DIABETES .</p> <p>Review of the Physician order dated 10/14/2024, revealed .RISPERIDONE TAB 0.5MG Give 1 tablet orally three times a day related to BRIEF PSYCHOTIC DISORDER .</p> <p>Review of the Physician order dated 1/13/2025, revealed .MEGESTROL AC [acetate] [NAME] [suspension] 40MG/ML [milliliter] Give 10 ml orally three times a day for appetite .</p> <p>Review of Resident #63's MAR (medication administration record) dated 2/2025, revealed the following medications were not administered as ordered on 2/6/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</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>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 2/2025, revealed the following medications were not administered as ordered on 2/9/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC (acetate) 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>e. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>Review of Resident #63's MAR dated 2/2025, revealed the following medications were not administered as ordered on 2/10/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>e. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>Review of Resident #63's MAR dated 2/2025, revealed the following medications were not administered as ordered on 2/21/2025.</p> <p>a. Insulin Aspart 100unit/ml was not administered for the 4:00 PM dose.</p> <p>Review of Resident #63's MAR dated 2/2025, revealed the following medications were not administered as ordered on 2/23/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER Northbrooke Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Physicians Dr Jackson, TN 38305	
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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>e. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/2/2025.</p> <p>a. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/10/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/11/2025.</p> <p>a. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/14/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/18/2025.</p> <p>a. Megestrol AC 40mg/ml was not administered for the 11:00 AM dose.</p> <p>b. Insulin Aspart 100unit/ml was not administered for the 4:00 PM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/19/2025.</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>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/20/2025.</p> <p>a. Insulin Aspart 100unit/ml was not administered for the 11:00 AM and 4:00 PM dose</p> <p>b. Megestrol AC 40mg/ml was not administered for the 11:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/20/2025.</p> <p>a. Insulin Aspart 100unit/ml was not administered for the 4:00 PM dose</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/23/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/25/2025.</p> <p>a. Divalproex 125mg was not administered for the 6:00 AM dose.</p> <p>b. Levothyroxine 25mcg was not administered for the 6:00 AM dose.</p> <p>c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose.</p> <p>d. Risperidone 0.5mg was not administered for the 6:00 AM dose.</p> <p>e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose.</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>Review of Resident #63's MAR dated 3/2025, revealed the following medications were not administered as ordered on 3/27/2025.</p> <ul style="list-style-type: none"> a. Divalproex 125mg was not administered for the 6:00 AM dose. b. Levothyroxine 25mcg was not administered for the 6:00 AM dose. c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose. d. Risperidone 0.5mg was not administered for the 6:00 AM dose. e. Insulin Aspart 100unit/ml was not administered for the 5:00 AM dose. <p>Review of Resident #63's MAR dated 4/2025, revealed the following medications were not administered as ordered on 4/6/2025.</p> <ul style="list-style-type: none"> a. Divalproex 125mg was not administered for the 6:00 AM dose b. Levothyroxine 25mcg was not administered for the 6:00 AM dose c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose d. Risperidone 0.5mg was not administered for the 6:00 AM dose e. Insulin Aspart 100 unit/ml was not administered for the 5:00 AM dose. <p>Review of Resident #63's MAR dated 4/2025, revealed the following medications were not administered as ordered on 4/10/2025.</p> <ul style="list-style-type: none"> a. Divalproex 125mg was not administered for the 6:00 AM dose b. Levothyroxine 25mcg was not administered for the 6:00 AM dose c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose d. Risperidone 0.5mg was not administered for the 6:00 AM dose e. Insulin Aspart 100 unit/ml was not administered for the 5:00 AM dose. <p>Review of Resident #63's MAR dated 4/2025, revealed the following medications were not administered as ordered on 4/11/2025.</p> <ul style="list-style-type: none"> a. Divalproex 125mg was not administered for the 6:00 AM dose b. Levothyroxine 25mcg was not administered for the 6:00 AM dose c. Megestrol AC 40mg/ml was not administered for the 6:00 AM dose <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>d. Risperidone 0.5mg was not administered for the 6:00 AM dose</p> <p>e. Insulin Aspart 100 unit/ml was not administered for the 5:00 AM dose.</p> <p>Review of Resident #63's MAR dated 4/2025, revealed the following medications were not administered as ordered on 4/12/2025.</p> <p>a. Insulin Aspart 100 unit/ml was not administered for the 5:00 AM dose.</p> <p>During an interview of 4/16/2025 at 8:41 AM, the Director of Nursing (DON) was made aware that there were multiple blanks on the residents MAR for scheduled medications in February, March, and April 2025, and no documentation showing reasoning for unsigned medications. The DON was asked if scheduled medication administrations should be signed out. The DON stated, Yes, it should be signed out. The DON was asked if an unsigned medication administration represents an error or missed dose. The DON stated, If it's not signed out you have to assume it wasn't done.</p> <p>3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Acute Respiratory Failure and Chronic Kidney Disease, Stage 3.</p> <p>Review of the Annual MDS assessment dated [DATE], revealed a BIMS score of 10 which indicated Resident #6 was moderately cognitively impaired. There was no indwelling catheter noted.</p> <p>Review of the undated Care Plan revealed Resident #6 was .receiving diuretics on a regular basis .at risk for UTI due to history of UTIs [urinary tract infections] .unable to maintain O2 [oxygen] Saturation. Receives oxygen as ordered .has oxygen therapy r/t [related to] respiratory failure, CHF [Congestive Heart Failure], Enhance Barrier Precautions Required: Resident requires enhanced barrier precautions during high contact resident care activities secondary to indwelling catheter and wound [4/13/2025] .has an Indwelling Catheter [4/13/2025] .</p> <p>Review of the Fluid Output dated 4/12/2025, revealed Resident # had a urinary output of 300.</p> <p>Observation in Resident #6's room on 4/13/2025 at 8:49 AM, revealed a urinary catheter bag attached to the left side of bed and no enhanced barrier precaution signage on the door.</p> <p>Review of the Order Summary Report revealed Resident#6 had no order for indwelling catheter and Enhanced Barrier Precautions.</p> <p>Review of the progress notes during the month of April 2025, revealed no documentation of insertion of indwelling catheter.</p> <p>During an interview on 4/13/2025 at 12:30 PM, LPN A was asked whether there was an order for an indwelling catheter, and she verified no order was found. She also verified there was no signage on the door.</p> <p>During an interview on 4/16/2025 at 7:50 AM, Nurse P was asked when indwelling catheter for Resident #6 was placed, she stated there was no documentation related to catheter placement. Nurse P stated whoever placed the order for the foley should have placed the order for enhanced precautions.</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 on 4/16/2025 at 8:13 AM, the DON stated an order should be obtained prior to the placement of an indwelling catheter, Enhanced Barrier Precautions should be ordered prior to placement of the indwelling catheter and documentation of the insertion of the indwelling catheter should be done.</p> <p>49269</p> <p>50408</p> <p>51365</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909</p> <p>Based on policy review, medical record review, observation, and interview, it was determined the facility failed to follow physician orders, failed to provide pressure ulcer/injury treatments, and failed to ensure a pressure reducing mattress was properly implemented for 3 of 3 (Resident #20, #47 and #63) sampled residents determined to have pressure ulcers/injuries.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Pressure Injuries Overview dated March 2020, revealed Pressure Ulcer/Injury refers to localized damage to the skin and/or underlying soft tissue .A pressure injury will present as intact skin and may be painful .A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful .Pressure ulcers/injuries occur as a result of intense and/or prolonged pressure .Stage 3 Pressure Injury: Full-thickness skin loss .in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present .Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar .Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation reveals a dark wound bed or blood-filled blister .</p> <p>Review of the facility's policy titled, Prevention of Pressure Injuries dated April 2020, revealed .Assess the resident on admission .for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition .Conduct a comprehensive skin assessment upon admission .with each risk assessment, as indicated according to the resident's risk factors .Inspect skin daily on a daily basis when performing or assisting with personal care or ADLs [activities of daily living] .Identify any signs of developing pressure injuries .inspect for changes in skin tone, temperature, and consistency .Inspect pressure points . sacrum, heels, buttocks, coccyx .Reposition all residents with or at risk of pressure injuries .Review and select medical devices with consideration to the ability to minimize tissue damage .Monitor regularly for comfort and signs of pressure-related injury .Evaluate, report and document potential changes in the skin .</p> <p>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 .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 .</p> <p>2. Review of the medical record revealed Resident #20 was admitted on [DATE], with diagnoses including Diabetes, Anemia, and Hypertension.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #20's Brief Interview Mental Status (BIMS) was 15 indicating intact cognition. Functional status was coded as moderate assistance from staff for activities of daily living (ADLs).</p> <p>Review of Resident #20's care plan dated 3/26/2025, revealed .[Named Resident] has pressure injury and is at risk for worsening of pressure injury, acquired pressure injury, and re-opening of resolved pressure injury due to compromised tissue damage r/t [related to]incontinence .UNSTG [Unstageable] pressure injury to (left buttock) will show signs of healing and remain free from infection by/through review date .STG [Stage] 3 pressure injury to (sacrum) will show signs of healing and remain free from infection by/through review date .</p> <p>Review of the Braden Scale (a standardized tool used in healthcare to assess a patient's risk for developing pressure injuries) dated 3/26/2025, revealed Resident #20 had a score of 16 which indicated a moderate risk for developing pressure ulcers.</p> <p>Review of Resident #20's Physician Orders dated 3/26/2025, revealed .Cleanse PRESSURE INJURY on LEFT BUTTOCKS with NS [normal saline], pat dry, apply CALCIUM ALGINATE and cover with dry dressing QD [each day] and PRN [as needed] .</p> <p>Review of Resident #20's Physician Orders dated 3/26/2025, revealed .Cleanse PRESSURE INJURY on sacrum with NS, pat dry, apply CALCIUM ALGINATE and cover with a dry dressing QD and PRN .</p> <p>Review of the March and April 2025 Treatment Administration Record (TAR) revealed Resident #20 had missed treatments to the Unstageable Pressure Ulcer to the left buttock on the following days:</p> <p>a.March 28, 2025</p> <p>b. March 31, 2025</p> <p>c.April 7, 2025</p> <p>Review of the March and April 2025 TAR revealed Resident #20 had missed treatments to the Stage 3 Pressure Ulcer to the sacrum on the following days:</p> <p>a.March 28, 2025</p> <p>b.March 31, 2025</p> <p>c.April 7, 2025</p> <p>Observations in the Resident's room on 4/14/2025 at 2:02 PM, and 4/15/2025 at 10:30 AM, revealed Resident #20's EMAX PRO pressure relief low air mattress did not have a pump at the end of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/14/2025 at 3:10 PM, the Director of Nursing (DON) was asked if Resident #20's bed should have a pump on her bed. The DON stated, I will check on that .</p> <p>Observation and interview in Resident's room on 4/15/2025 at 2:30 PM, revealed the Maintenance Director putting a pump on Resident #20's EMAX PRO Low Air Loss Mattress. The Maintenance Director confirmed Resident #20's bed should have had a pump intact in order to provide pressure relief for her wounds.</p> <p>Review of Physician Order dated 4/15/2025, revealed Low Air Loss Mattress every day and night shift for wound</p> <p>During an interview on 4/15/2025 at 3:00 PM, the DON was asked should a resident present with a Stage 3 Pressure Ulcer on first observation of the wound. The DON stated, no, the previous nurse could not tell me what wounds were in the facility, so we did a skin sweep and this was found . The DON was asked when wound treatments are completed by the licensed nurse. The DON stated, the nurse follows Physician Orders and performs the wound treatments, then documents those treatments .if it's not documented, it's not done .the treatments should be completed and documented . The DON confirmed the appropriate Low Air Loss Mattress should be in place with the appropriate pump in order to provide pressure relief for the wound.</p> <p>3. Review of the medical record review revealed Resident #47 was admitted to the facility on [DATE] with diagnoses including Cerebrovascular Disease with Hemiplegia, Pressure Ulcer, Hepatitis C, and Schizophrenia.</p> <p>Review of a Skin assessment dated [DATE], revealed Resident #47 had acquired a stage 3 to his sacrum, with a start date of 2/13/2025.</p> <p>Review of a Braden Scale dated 2/14/2025, revealed Resident #47 Braden score was 11, meaning he is at high risk for developing pressure ulcers.</p> <p>Review of the Physician Orders dated 3/13/2025, revealed Cleanse Pressure Injury on Sacrum with NS (normal saline) .Silver Alginate and cover with dry dressing QD (every day) and PRN (as needed) .</p> <p>Review of the MDS dated [DATE], revealed Resident #47 has a BIMS score of 14 which indicated Resident #47 was cognitively intact. Further review revealed Resident #47 has a Stage 3 Pressure Ulcer.</p> <p>Review of the Care Plan dated 3/21/2025, revealed .has pressure ulcer and is at risk for worsening .acquired pressure injury .stage 3 pressure injury to sacrum .</p> <p>Review of the February, March and April Treatment Administration Record (TAR) revealed Resident #47 has missed treatments on the following days</p> <p>a. 2/13/2025</p> <p>b. 2/14/2025</p> <p>c. 2/15/2025</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>d. 2/16/2025</p> <p>e. 2/17/2025</p> <p>f. 3/18/2025</p> <p>g. 3/19/2025</p> <p>h. 3/21/2025</p> <p>i. 3/28/2025</p> <p>j. 4/1/2025</p> <p>During an observation on 4/13/2025 at 11:16 AM, 11:44 AM, 12:05 PM and 2:45 PM, 4/14/2025 at 7:39 AM, and 3:06 PM, 4/15/2025 at 7:52 AM, and 4/16/2025 at 8:55 AM. Resident #47 was laying on a bolster mattress.</p> <p>During an observation on 4/15/2025 at 10:36 AM, revealed the Maintenance Supervisor changing bolster bed out for a low loss mattress.</p> <p>4. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Severe Protein-Calorie Malnutrition, Diabetes, Dysphagia, Anxiety, Gastrostomy Status, and Alzheimer's.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #63 had severely impaired cognition. Resident was dependent for bed mobility, transfers, eating, and toileting. Pressure reducing device for chair and bed.</p> <p>Review of the care plan dated 2/21/2025, revealed a focus for pressure injury, enhanced barrier precautions, weight loss and malnutrition r/t poor PO (by mouth) intake and wounds.</p> <p>Review of the Braden Scale (a standardized tool used in healthcare to assess a patient's risk for developing pressure injuries) dated 2/14/2025, revealed Resident #63 had a score of 13 which indicated moderate risk.</p> <p>Review of the Braden Scale dated 4/13/2025, revealed Resident #63 had a score of 10 which indicated high risk.</p> <p>Review of the Skin Assessment (Pressure Injury)-WGC form dated 2/24/2025, revealed .NEW AREA .Left heel Intact serous filled blister .Date of onset 2/24/2025 .</p> <p>Review of the Physician Order dated 2/28/2025, revealed . Cleanse PRESSURE INJURY on left heel with NS (normal saline), pat dry, apply iodine and place offloading boots to foot as needed AND every day shift .</p> <p>(continued on next page)</p>		

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

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Treatment Administration Record (TAR) for 3/2025 and 4/2025, revealed . Cleanse PRESSURE INJURY on left heel with NS, pat dry, apply iodine and place offloading boot to foot .every day shift -Start Date- 03/01/2025 0700 -D/C (discontinue) Date- 04/07/2025 1539 .</p> <p>Review of the March 2025 TAR revealed Resident #63 had missed treatments to the left heel on the following days.</p> <p>a.3/19/2025</p> <p>b. 3/20/2025</p> <p>c. 3/21/2025</p> <p>d. 3/28/2025</p> <p>Review of the April 2025 TAR revealed Resident #63 had missed treatments to the left heel on the following days.</p> <p>a. 4/5/2025</p> <p>Review of the Physicians wound evaluation and management summary dated 4/7/2025 revealed a unstageable DTI (deep tissue injury) to sacrum with undetermined thickness- Duration > 1 days-- measurements 2.8 x 3.8 x not measurable cm (centimeter). Intact with purple/maroon discoloration. Dressing treatment plan - Primary dressing- alginate calcium with silver apply once daily for 30 days; xeroform gauze apply once daily for 30 days.</p> <p>Review of the Physicians wound evaluation and management summary dated 4/9/2025 revealed a unstageable DTI sacrum undetermined thickness-Duration >3 Days--measurements 1.4 x 1.4 x not measurable cm. Intact with purple/maroon discoloration. Dressing treatment plan - Primary dressing- xeroform gauze apply once daily for 28 days; Alginate calcium w/silver apply once daily for 28 days.</p> <p>Review of the TAR dated 4/2025, revealed there were no treatment orders entered for a DTI to sacrum.</p> <p>Observation in resident's room on 4/13/2025 at 9:13 AM, revealed Resident #63 was resting in bed, eyes closed, bed alarm to bed and on, no pump in use on mattress, water pitcher on over bed table.</p> <p>Observation in resident's room on 4/15/2025 at 3:50 PM, revealed Resident #63 resting in bed placed on a low air loss mattress today pump running.</p> <p>During an interview on 4/15/25 at 3:13 PM, the Director of Nursing (DON) confirmed the left heel wound originated as a fluid filled blister on 2/24/2025, treatment to area was not ordered until 2/28/2025, and that a treatment should have been initiated the date the wound was found.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/16/2025 at 8:38 AM, the DON was asked if prior to 4/15/2025 was Resident #63 on the appropriate mattress for a resident with a stage 3 pressure ulcer. The DON stated, No. The DON was asked if completed treatments should be signed out on the TAR. The DON stated, Yes. The DON was asked if there is no documentation for treatment on the TAR, would it be considered done. The DON stated, If it's not signed it's not done.</p> <p>During an interview on 4/16/2025 at 11:45 AM, the DON was shown documentation from dates 4/7/2025 and 4/9/2025 of observation and measurement of sacral ulcer. Resolved on 4/14/2025. The DON was asked was there a sacral ulcer found on Resident #63. The DON stated, Yes, The DON was asked if a treatment was entered for that wound. The DON replied, No.</p> <p>50408</p> <p>51365</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269</p> <p>Based on policy review, medical record review, and interview, the facility failed to follow interventions to prevent falls for 1 of 4 (Resident #328) reviewed for falls.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility policy titled, Falls and Fall Risk Managing, revised 3/2018, revealed .the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling . 2. Review of the medical record revealed Resident #328 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, Depression, Diabetes, Malignant Neoplasm of Breast, and Abdominal Aortic Aneurysm. <p>Review of the Care Plan dated 1/17/2025, revealed .At Risk for Falls R/T [related to] weakness, difficulty with transfers .Interventions .use [Named] lift [mechanical device used to transfer individuals with mobility limitations from one surface to another] and 2 assist [assistance] for transfers .,</p> <p>Review of the admission Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12, which indicated Resident #328 was moderately cognitively impaired, and totally dependent on staff for transfers and had 1 fall with no injury since admission.</p> <p>Review of the Morse Fall assessment dated [DATE], revealed Resident #328 was at moderate risk for falls.</p> <p>Review of the facility's Fall Investigation dated 3/11/2025, revealed .Resident slid out of stand-up lift [mechanical lift that uses a sling to wrap around resident's waist and allows the resident to be in the standing position holding on to each side] while being transferred from her wheelchair to the bed .Resident stated arms slipped out of the sling .No injuries observed at the time of incident .Education needed on appropriate mechanical lifts for resident .</p> <p>Review of an Occupational Therapy [OT] Discharge Summary revealed .Dates of Service 2/4/2025- [to] 3/12/2025 .Chair/bed transfers .total dependency .</p> <p>Review of a Physical Therapy [PT] Discharge Summary revealed .Dates of Service 2/4/2025-3/12/2025 .not able to bring self to standing with mechanical sit to stand lift .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 4/14/2025 at 8:10 PM, Certified Nursing Assistant (CNA) Q stated, .she wanted to be put in bed, I was not familiar on how she transferred from the wheelchair to the bed, I asked her how, she [Resident #328] .they use the stand up lift .myself and another aide attempted to transfer her from the wheelchair by lifting her under her arms, we could not do it so we got the stand-up lift .and we had her strapped to the lift but her arms gave out and she started to slide out of the lift to the floor .I did not look in the kiosk [electronic medical record] or care plan to see how to transfer her .the resident told me they use the stand up lift so I used it .</p> <p>During an interview on 4/15/2025 at 10:00 AM, the Therapy Director stated, .the resident was admitted . use Hoyer lift [mechanical lift that lifts the resident totally out of bed with a sling] for transfers and was total dependent with transfers .PT was working on sit to stand and stand-up lift and the parallel bars but [Resident #328] could not tolerate sit to stand lift .on admission she was a Hoyer lift for transfer and that never changed .it is documented on the care plan and the Kardex [a manual plan of care used by CNAs to refer to for care] . Night shift should have looked at the Kiosk Kardex or care plan on how to transfer .</p> <p>During an interview on 4/16/2025 at 9:12 AM, CNA R stated .it was not reported to her .on how this resident was to transfer from the wheelchair to the bed and we did not check the care plan or Kardex summary .we should have checked before transferring the resident instead of asking the resident .</p> <p>During an interview on 4/16/2025 at 1:00 PM, the Director of Nursing (DON) stated, .Staff should look at the Kardex or care plan before transferring a resident and not ask the resident .</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services for residents with enteral feedings when staff failed to ensure the enteral feeding, the feeding syringe and the flush solution were properly labeled for 2 of 3 sampled residents (Resident #11 and Resident #61) reviewed with Percutaneous Endoscopic Gastrostomy (PEG) tube feedings.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the policy titled, Enteral Nutrition, dated 11/2018, revealed Adequate nutritional support through enteral nutrition is provided to residents as ordered The nurse confirms that orders for enteral nutrition are complete .Complete orders include .the enteral product .specific enteral access device .administration method .volume and rate of administration .instructions for flushing . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Dementia, and Cerebral Infraction, and Dysphagia. <p>Review of the admission Minimum Data Assessment (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #11 had severely impaired cognition and had a feeding tube.</p> <p>Review of the physician orders dated 4/1/2025 revealed .every shift for PEG tube Enteral Feeding: Glucerna 1.5 @ 65cc/hr [hour]via [by]PEG tube with 100ml [milliliters]water flush every 4 hours .</p> <p>Review of the physician orders dated 3/19/2025, revealed .every night shift for Peg tube ENTERAL: Change enteral syringe Q [every] 24hrs AND as needed for Peg tube Enteral: Change enteral syringe PRN [as needed] .</p> <p>Observation on 4/13/2025 at 8:57 AM, revealed Resident #11's enteral feeding and water bottle/bag was hung on the pole and running with no rate, no date, no resident's name, no time and no nurse initial. There was an undated, opened, bagged syringe on the pole.</p> <p>Observation on 4/13/2025 at 9:59 AM, revealed Resident #11's enteral feeding and the water bottle was labeled with the roommate's name, and had no rate.</p> <p>During interview 4/13/2025 10:05 AM, Licensed Practical Nurse (LPN) O confirmed when she entered Resident #11's room the enteral feeding and water bottle was not labeled.</p> <p>Observation and interview in the resident's room on 4/13/2025 at 10:09 AM, revealed LPN O confirmed she had written the wrong name on the resident's enteral feeding and water bottle. There was no rate on the enteral feeding and the water bottle had no date and rate.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #61 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Dysphagia, and Parkinson's. <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #61 had intact cognition, and had a feeding tube</p> <p>Review of the physician orders dated 4/2/2025 revealed .every shift for PEG tube Enteral Feeding: Glucerna 1.5 @ [at] 70ml/hr with 150ml of water Q4H continuously via PEG tube .</p> <p>Review of the physician orders dated 3/10/2025, revealed .every night shift for continuous feeding ENTERAL: Change enteral tubing Q 24hrs AND as needed for continuous feeding Enteral: Change enteral tubing PRN .</p> <p>Observation on 4/13/2025 at 9:08 AM, revealed Resident # 61 enteral feeding and water bottle was not labeled, except for the resident's last name room.</p> <p>During an interview on 4/13/2925 at 9:42 AM, Registered Nurse (RN) I confirmed the enteral syringe should be labeled with the nurse's initials, a date and should be changed every 24 hours .</p> <p>During an observation and interview in Resident#61's room on 4/13/2025 at 9:58 AM, Registered Nurse (RN) I confirmed the resident enteral feeding and water bottle had no label except the last name.</p> <p>During an interview on 4/16/2025 at 8:07 AM, the Director of Nurses was asked how enteral feeding and the water bottle for flushing should be labeled. The DON stated, With a date, rate, time, nurse initial, and the resident's name.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51740</p> <p>Based on policy review, medical record review, observation, and interview the facility failed to obtain physician orders, failed to ensure the physician orders were being followed, and failed to accurately care plan for 3 of 4 (Residents #29, #36, #478) sampled residents reviewed for respiratory therapy.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled Oxygen Administration, dated 4/2/2007, revealed .to provide guidelines for safe oxygen administration .Verify that there is a physician's order .Adjust the oxygen device so the proper flow of oxygen is being administered .</p> <p>Review of the facility policy titled Medication and Treatment Orders, dated 7/2016, revealed .Medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medication in this state .</p> <p>2. Review of the medical record revealed Resident # 29 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Diabetes, Heart Failure, and Depression.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident # 29 was cognitively intact. Resident was on oxygen.</p> <p>Review of the Care Plan dated 4/3/2025, revealed . [named resident] has oxygen therapy .Oxygen settings . The resident has O2 [Oxygen] via [by way of] nasal .@ [at] 2 L [Liters] continuously .</p> <p>Observations in the Resident's room on 4/13/2025 at 9:13 AM, 4/14/2025 at 10:10 AM, and on 4/15/2025 at 8:02 AM, revealed resident with O2 at 2L via binasal cannula (BNC).</p> <p>The facility failed to obtain a physician's order for oxygen therapy.</p> <p>3. Review of the medical record revealed Resident # 36 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Bipolar Disorder, Dysphagia, and Tracheostomy.</p> <p>Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 99 due to severely cognitively impaired. Resident # 36 was on continuous oxygen therapy.</p> <p>Review of the Care Plan dated 3/12/2025, revealed .receives Oxygen Therapy @ [at] 2L/min [2 Liters per minute] via [by way of] trach mask .has Tracheostomy .</p> <p>Observation in the Resident's room on 4/13/2025 at 2:50 PM, revealed resident with oxygen [o2] concentrator at bedside set on 6.5 L via tracheostomy (trach).</p> <p>Observations in the Resident's room on 4/14/2025 at 8:09 AM, 4:46 PM, and on 4/15/2025 at 8:00 AM, revealed resident with O2 concentrator at 7L via trach.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/16/2025 at 8:42 AM, the Director of Nursing (DON) confirmed that oxygen should have an order and the care plan should match.</p> <p>The facility failed to obtain a physician's order for the quantity of liters for oxygen therapy and the care plan was not accurate.</p> <p>4. Review of the medical record revealed Resident #478, was admitted to the facility on [DATE], with diagnoses including, Chronic Kidney Disease Stage 3, Chronic Pain, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Physician's Orders dated 4/11/2025, revealed .oxygen administer O2 [oxygen] @ [at] 2L/min [Liters per minute] via [by way of] BNC [binasal cannula] continuously .</p> <p>Review of Care plan dated 4/13/2025, revealed . OXYGEN SETTINGS: The resident has O2 via nasal cannula @ 2L continuously .Administer medications as ordered by physician .</p> <p>Observation in the resident's room on 4/13/2025 at 09:26 AM, revealed Resident #478 received oxygen at 8L BNC.</p> <p>Observation and interview in the resident's room on 4/13/2025 at 11:49 AM, revealed Resident #478 received oxygen at 8 Liters BNC. RN I confirmed the oxygen should be on 2L BNC,</p> <p>During an interview on 04/16/2025 at 8:12 AM, the DON confirmed staff should follow physician orders.</p> <p>The facility failed to follow physician order for oxygen therapy flow rate.</p>

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>46047</p> <p>Based on review of the facility's Licensure Staffing Requirements, daily staffing schedules, and interview, the facility failed to ensure a Registered Nurse (RN D and MDS Coordinator) was on duty at least 8 hours a day, 7 days a week, for 2 of 28 days reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's Nursing Home Daily Staffing schedules for March 2025 and April 2025 revealed no RN on duty for 8 consecutive hours on 3/16/2025 and 4/6/2025. 2. Review of the facility's daily working schedule for March 2025 and April 2025 confirmed no RN on duty for 8 consecutive hours on 3/16/2025 and 4/6/2025. 3. During an interview on 4/16/2025 at 11:47 AM, the Staffing Coordinator, was asked how many consecutive RN hours a day are required. The Staffing Coordinator stated, Eight. Then The Staffing Coordinator was shown the facility's NURSING HOME LICENSING CHECKLIST, dated 3/15/2025 - 3/28/2025 and 3/29/2025 -4/11/2025. The staffing Coordinator was asked about the 3/16 with 6.5 RN hours, Staffing Coordinator stated, [Named RN D] must have left early that day and [MDS Coordinator] must have left early on 4/6/2025 when there was 6.12 RN hours .

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>30974</p> <p>Based on policy review, daily staff posting review, and interview, the facility failed to post the total number of staff, and actual hours worked by the licensed staff responsible for resident care on the facility's Daily Staff Posting form for 31 of 31 sampled days.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's Daily Staff Posting forms were not completed for 31 of the 31 days requested. 2. During an interview on 4/16/2025 at 12:05 PM, the Staffing Coordinator was asked where the staff postings were located. The Staff Coordinator stated, We have them on the computer, I don't post them or print them for this company .

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 3 of 6 staff member (Registered Nurse (RN)), Licensed Practical Nurse (LPN) J) left medication unattended, and out of sight, and opened oral medications were stored in a medication cup, when a medication was stored at bedside in 1 of 79 occupied rooms, when 1 of 6 medication carts (300 hall) was left unlocked, unattended, and out of sight of staff, when 3 of 6 (300 hall, 200 hall, and the short stay) medication carts had holes/cracks in the drawers.</p> <p>The findings include:</p> <p>1. Review of the policy titled, Medication Labeling and Storage, dated 2/2023, revealed .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light. Only authorized personnel have access to keys .Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparations areas are in a clean, safe, and sanitary manner. Medication carts and storage rooms containing medications and biologicals or carts used to transport such items are not left unattended if open or otherwise potentially available to others .</p> <p>2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease and Dysphagia.</p> <p>Review of the quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #21 had intact cognition.</p> <p>A random observation in the 400-hall medication cart on 4/15/2025 at 3:34 PM, revealed oral medications in a cup. Licensed Practical Nurse (LPN) J confirmed the oral medications were Resident #21's 9 AM and 11 AM meds. The Regional Quality Service confirmed the meds needed to be disposed.</p> <p>3. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE], with diagnoses including Hypertension and Diabetes</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #46 had intact cognition.</p> <p>Review of the Physician's Order dated 4/3/2025, revealed .Novolog [Insulin aspart-lowers blood sugar levels] Injection Solution 100 Unit/[per]ML [milliliters] Inject as per sliding scale .</p> <p>Observation during med pass on 4/14/2025 at 4:39 PM, revealed Registered Nurse (RN) I failed to perform hand hygiene, gathered and pushed the pill from the medication card into a med cup, placed the medication card into the med cart, gathered supplies, left a vial of insulin on the medication cart, and entered Resident #46's room.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Northbrooke Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 121 Physicians Dr Jackson, TN 38305	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease (COPD) and Dysphagia.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #52 had intact cognition.</p> <p>Review of the Physician's Order dated 1/4/2025, revealed . Breztri Aero Aer Sphere [Breztri Aerosphere-inhaler used to improve symptoms of COPD for better breathing and to reduce the number of flare-ups] 2 puffs inhale orally 2 times per day .</p> <p>Observation and interview on 4/15/2025 at 8:44 AM, revealed LPN J, entered Resident #52's room to confirm whether there was a Breztri inhaler stored at Resident #52s bedside table. LPN J confirmed the Breztri inhaler was stored on the resident's over the bed table and there was no opened date on the inhaler.</p> <p>5. Observation on 4/13/2025 at 10:20 AM, revealed the 300-hall medication cart unlocked and unattended. LPN C confirmed the med cart was left unattended and unlocked and should not have been.</p> <p>During an interview on 4/14/2025 at 4:46 PM RN I confirmed Resident #46's vial of insulin should not have been left unattended and out of sight and should have been placed in the med cart.</p> <p>During an interview on 4/15/2025 at 1:09 PM, the Director of Nurses confirmed medication should not be kept at a residents' bedside, an over the bed table was not an appropriate med storage area, and resident's meds should be stored out of the reach and sight of others.</p> <p>6. Observations on 4/15/2025 at 3:13 PM, revealed the Administrator, the Regional Quality Service, and LPN C confirmed the 300-med cart's second drawer and third drawer had a hole/cracked. The crack in the second drawer of the 300-hall cart was big enough that the surveyor could take hold and pull out the plastic wrapped, multi dose medication packs. LPN C confirmed she was aware of the holes in the 300 hall cart drawers and did not notify anyone.</p> <p>Observations on 4/15/2025 at 3:28 PM, the Administrator, the Regional Quality Service and LPN K confirmed the med cart 200 hall med cart's drawer second drawer was cracked. The crack in the second drawer of the 200-hall cart was big enough that the surveyor could take hold and pull out the plastic wrapped, multi dose medication packs.</p> <p>Observation on 4/15/2025 at 3:39 PM, the Administrator, the Regional Quality Service, and LPN H confirmed the short stay med cart's second drawer had a crack. LPN confirmed she was aware on 4/14/2025 and did not notify management.</p> <p>4/15/2025 at 3:44 PM, the Regional Quality Service confirmed the cracked drawers of the 300 hall, 200 hall and short stay hall med carts needed to be replaced.</p> <p>During an interview on 04/16/25 08:07 AM, the Director of Nurses confirmed staff should not leave medications unattended, opened medications should not be stored on top of the medication cart and medications not given in a timely matter should not be stored in a medication cup in the med cart.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 4/16/2025 at 12:15 PM, the Director of Nursing was asked what her expectation are related to the securing of the medication cart. The DON confirmed she expects the medication cart to be locked with no medication left on top of the cart and the computer should be closed. The DON was asked if there was ever a time when it was okay to leave the medication cart unsupervised and unsecured. The DON stated, No.</p> <p>The facility failed to ensure medications were properly stored and secured.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51365</p> <p>Based on policy review, observation, refrigerator and freezer temperature logs, and interview, the facility failed to ensure food was stored, handled, prepared, and served under sanitary conditions. Food items stored unlabeled and undated, stored beyond use by date, and stored on freezer floor. Staff personal items sitting on workstation on top of equipment. Plastic storage containers and lids were dirty with sticky residue, metal table with rust on surface, ice machine had fuzzy debris hanging out of filter, and food trays stored with standing water on them. Drinks sitting out uncovered. Hand hygiene not performed when plating food and loading meal cart. The facility failed to maintain temperature logs for two nourishment refrigerator/freezers. The facility had a census of 79 with 74 of those residents receiving a tray from the kitchen.</p> <p>The findings include:</p> <p>1. Review of the undated facility policy titled Food Storage, revealed .Food is stored, prepared, and transported .by methods designed to prevent contamination .Hands must be washed after unloading supplies and prior to handling any food item .Food is stored a minimum of 6 inches above the floor on clean racks, dollies or other clean surface .Leftover food is stored in covered containers .Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 48 hours or discarded .Temperatures for refrigerators should be 41 degrees F and below. They must be recorded daily .Every refrigerator must be equipped with an internal thermometer .Temperatures for freezer should be 0 degrees or below and must be recorded daily .Every freezer must be equipped with an internal thermometer .To freeze leftover food, package .label and date .</p> <p>Review of the undated facility policy titled Resident Personal Food Storage and Handling, revealed .A separate refrigerator specifically intended for resident food will be maintained by the facility .All prepared/perishable food or beverages brought in by resident, family or visitors for resident's use will be labeled with the resident's name and the date the item was stored .All food and beverage must be labeled and dated with resident name and date otherwise it shall be discarded .Resident food will be kept for 5 days from the label date and then discarded .Staff will monitor temperature control of unit refrigerators .This policy will be posted on units with refrigerators for resident food storage .</p> <p>Review of the undated facility policy titled Outside Food Policy, revealed .Labeling and Storage .All food brought into the facility should be .Clearly labeled with resident's name .Dated with the date of delivery . Unlabeled or expired food will be discarded .</p> <p>2.Observation in the kitchen on [DATE] at 8:23 AM, revealed the following.</p> <p>Large amount of raw chicken in standing water in a large sink, not in a bowl or on a pan, no running water noted.</p> <p>Staff had personal items sitting on workstation with a purse and a phone on a toaster.</p> <p>Wet nesting on 2 red food trays on the clean rack.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4 one-gallon cans of food on floor holding door open to dry storage room.</p> <p>2 one-gallon pitchers of dark colored liquid unlabeled and undated sitting on counter.</p> <p>A bag of frozen celery with use by date of [DATE] in the walk-in freezer.</p> <p>An open box of chicken 8 piece cut sitting on the freezer floor.</p> <p>A bag of dinner rolls with use by date of [DATE] in the walk-in freezer.</p> <p>An unlabeled and undated bag of sliced cheese in the walk-in refrigerator.</p> <p>6 trays of uncovered drinks on a cart without ice in them.</p> <p>Sticky residue on a large plastic container on the bottom clean rack in the dry storage room.</p> <p>Dirty plastic container lids with smears and sticky tan debris on a clean rack in the dry storage room.</p> <p>Ice maker with large amounts of fuzzy debris hanging out of filter, front ledge of machine at door and sides of machine stained with light brown discoloration.</p> <p>3. Observation in the kitchen on [DATE] at 11:03 AM, revealed the following.</p> <p>Dietary [NAME] #44 adjusted face mask with gloved hands and continued plating food, and tearing breadsticks apart without performing hand hygiene or changing gloves.</p> <p>Removed gloves when preparing to temp food and donned new gloves without completing hand hygiene.</p> <p>4. Observation in the kitchen on [DATE] at 11:14 AM, revealed the following.</p> <p>Dietary Aide #43 opened walk-in refrigerator with gloved hands, removed tray of salads and returned to filling meal cart without performing hand hygiene or changing gloves.</p> <p>5. Observation in the kitchen on [DATE] at 11:29 AM, revealed the following.</p> <p>Dietary [NAME] #44 moved cart of dishware around and continued plating food and tearing breadsticks apart without performing hand hygiene or changing gloves.</p> <p>6. Observation in the 400 Hall nourishment refrigerator/freezer on [DATE] at 12:15 PM, revealed the following.</p> <p>Brown sticky residue in the freezer, no thermometer in freezer or refrigerator areas, unlabeled/undated bag of grapes, bowl of tuna, ranch dip, cocktail shrimp, and bowl of salad. Temperature log on refrigerator door with only one temperature entry noted for [DATE] revealed [DATE], 38 degrees for refrigerator and freezer.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>7. Observation in the 100 Hall nourishment refrigerator/freezer on [DATE] at 12:21 PM, revealed the following.</p> <p>Temperature log on refrigerator door with only one temperature entry noted for [DATE] revealed [DATE], 32 degrees for both the refrigerator and freezer. Thermometer in freezer showed -5 degrees. No thermometer in refrigerator area. Undated/unlabeled cup of ice cream ,d+[DATE] empty, Smoothie King smoothie in the door of freezer undated and unlabeled. 2 half gallon tubs of ice cream undated/unlabeled in freezer. Unlabeled and undated pack of deli meat, 3 cartons of milk with expiration of [DATE]. Sticky dark areas on shelf and in drawers.</p> <p>8. Observation in the kitchen on [DATE] at 3:49 PM, revealed the following.</p> <p>A metal stand with metal bowl and colander on shelf and standing mixer on top noted to have brown rust colored substance on the legs and shelf of it.</p> <p>During an interview on [DATE] at 10:30 AM, the Certified Dietary Manager (CDM) was asked about the 6 trays of drinks sitting uncovered on a cart in kitchen. The CDM stated, .yes they are for lunch .they should be covered .we add ice prior to serving .</p> <p>During an interview on [DATE] at 4:07 PM, the CDM confirmed that food items should be labeled and dated, not stored past use by date, canned foods should not be used as a door prop, food trays should not be stored with standing water on them, plastic containers and lids should be free of sticky substances and debris, and food items are to always be off the floor of the freezer.</p> <p>During an interview on [DATE] at 3:49 PM, the CDM confirmed the brown rust colored substance on a metal stand with a shelf holding a metal bowl and colander and standing mixer was rust and it should not be there.</p> <p>During an interview on [DATE] at 8:28 AM, the Director of Nursing (DON) confirmed that nourishment refrigerators/freezers are for resident's food items only and should be clean, food should be labeled and dated, free of expired or outdated food items, have a thermometer, and temperature logs should be completed daily.</p> <p>During an interview on [DATE] at 11:10 AM, the CDM confirmed that staff's personal items should not be sitting on workstations or on equipment, and ice machines surface and filters should be clean.</p> <p>During an interview on [DATE] at 11:14 AM, the CDM was asked if hand hygiene and glove changes should be performed if staff opens a refrigerator, handles items, moves dinnerware carts, or adjust face masks with gloved hands when preparing meal trays. The CDM stated, Yes. The CDM confirmed that hand hygiene should be performed when staff puts on or takes off gloves.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408</p> <p>Based on Resident Rights, medical record review, and interview, the facility failed to maintain accurate medical records related to Cardiopulmonary Resuscitation (CPR) for 1 of 1 (Resident # 378) sampled residents reviewed for CPR.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Review of the undated .Resident [NAME] of Rights revealed It is designed to ensure residents receive care that respects their dignity, privacy and autonomy .Each resident shall have the right to .the resident's wishes and preferences must be considered in the exercise of rights . Review of the medical record review revealed Resident #378 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Pulmonary Disease, Congestive Heart Failure, Chronic Kidney Disease, and Diabetes. <p>Review of the .Physicians Order for Scope of Treatment (POST) form dated [DATE], revealed Resident #378 was to have full treatment CPR.</p> <p>Review of the Care Plan dated [DATE], revealed Resident #378 has a terminal diagnosis receiving Hospice services.</p> <p>Review of the Minimum Data Set (MDS) dated [DATE], revealed Resident #378 had a Brief Interview of Mental Status (BIMS) score of 14, meaning she was cognitively intact.</p> <p>Review of the Physician Order Sheet dated ,d+[DATE], revealed Resident #378 did not have an order for no CPR, nor Hospice services.</p> <p>Review of a Hospice admission form dated [DATE], revealed Resident #378 was admitted to Hospice and code status had changed to a Do Not Resuscitate (DNR)</p> <p>Review of the POST form dated [DATE], revealed Resident #378 was a DNR with comfort measures.</p> <p>Review of a .Soap Note dated [DATE] revealed, the Family Nurse Practitioner (FNP) asked Resident #378 about her code status, Resident #378 wishes to remain a full code with full treatment.</p> <p>Review of a .Soap Noted dated [DATE] revealed, FNP seen Resident #378 and spoke with family on this date and will consult Hospice.</p> <p>Review of a Progress Note dated [DATE] revealed, .This nurse was in the middle of med [medication] pass when CNA [Certified Nurse Aide] notified nursing at 0620 (AM) that patient went unresponsive. CPR started due to patient being Full code in computer. EMS [Emergency Medical System] notified and left with patient at 0640 CPR still in progress. Hospice contacted and stated she would follow up with EMS on DNR order .</p> <p>(continued on next page)</p>

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:58 AM, the Social Worker (SW) was asked the process of Hospice admission and POST forms. The SW confirmed the Hospice agency will meet at the facility and have a meeting. After the meeting the Hospice agency will give the admission forms and a new POST form to the facility. The SW confirmed the Medical Records department would have uploaded the new POST form for no CPR. The SW worker confirmed the new form should have been copied and updated and placed in the medical record.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on the CDC's [Center for Disease Control] Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings review, policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 1 of 79 occupied rooms contained a blood-tinged gauze, when 1 of 1 staff members (Certified Nurse Assistant (CNA) L) failed to properly store soiled linens, and when 5 of 5 staff members (Registered Nurse (RN) D and RN I, Licensed Practical Nurse (LPN A), CNA B and CNA L) failed to wear Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP) and Contact Precautions, when 1 of 6 staff members (LPN K failed to properly disinfect reusable medical equipment, when 1 of 6 staff members (LPN H) failed to properly store an enteral syringe, and when 3 of 3 staff members (LPN C, LPN H, and RN I) failed to perform hand hygiene.</p> <p>The findings include:</p> <p>1. Review of the CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings .Environmental Cleaning and Disinfection, revealed .References and resources: 4, 7, 10, 11, 13, 21 . Clean and disinfect surfaces in close proximity to the patient and frequently touched surfaces in the patient care environment on a more frequent schedule compared to other surfaces .Reprocessing of Reusable Medical Equipment References and resources: 2-4, 7-8, 11-13 .Clean and reprocess (disinfect or sterilize) reusable medical equipment (e.g., blood glucose meters and other point-of-care devices, blood pressure cuffs, oximeter probes, surgical instruments, endoscopes) prior to use on another patient or when soiled . Maintain separation between clean and soiled equipment to prevent cross contamination .CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings Infection Control CDC . www.cdc.gov/infection-control/hcp/core-practices/index.html</p> <p>Review of the facility policy titled, Laundry and Bedding, Soiled, dated September 2022, revealed .Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection control and practices .</p> <p>Review of the facility policy titled, Enhanced Barrier Precautions, dated 8/2022, revealed .Enhanced barrier precautions EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms(MDROs) .Gloves and gowns are worn prior to performing high contact resident care activity .examples .bathing .transferring .device care or use (central line, urinary catheter, feeding tube, tracheostomy) .wound care (any skin opening requiring a dressing) .</p> <p>Review of the facility policy titled, Isolation-Categories of Transmission-Based Precautions, dated 9/2022, revealed .Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the environment .wear gloves .when entering the room . wear a disposable or washable gown upon entering the room .</p> <p>(continued on next page)</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>Review of the facility policy titled, Handwashing/Hand Hygiene, dated 8/2019, revealed .The facility considers hand hygiene the primary means to prevent the spread of infection .Wash hands with soap .When hands are visibly soiled .After contact with a resident with infectious .Use an alcohol-based hand rub .or, alternatively, soap .and water for the following situations .Before and after direct contact with residents. Before preparing or handling medications .Before and after handling an invasive device(.IV access sites) . Before moving from a contaminated body site to a clean site .After contact with a resident's intact skin .After contact with objects (medical equipment) in the immediate vicinity of the resident .After removing gloves . Hand hygiene is the final step after removing and disposing of personal protection equipment</p> <p>Review of the facility policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 9/2022, revealed .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens</p> <p>Standard .</p> <p>2. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status, Dementia and Dysphagia.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 3, which indicates severely impaired cognition, and had a feeding tube.</p> <p>Review of the Physician's Order dated 4/1/2025, revealed Resident #11 had an order for enteral feeding by Percutaneous Endoscopic Gastrostomy (PEG) tube.</p> <p>Review of the Physician's Order dated 4/14/2025, confirmed Resident #11 had an order for Enhanced Barrier Precautions.</p> <p>Observation in Resident #11's room on 4/13/2025 at 3:22 PM, revealed RN I failed to wash hands, put on a gown and apply gloves before taking hold of the resident's PEG tubing at the peg site. RN I placed the tubing back, picked up and placed a trash can near the bedside, failed to perform hand hygiene before applying gloves, disconnected the enteral feeding tubing from peg site tubing, primed the line, reconnected the tubing, removed the gloves and failed to perform hand hygiene.</p> <p>During an interview on 4/13/2025 at 3:30 PM, RN I confirmed hand hygiene was not performed and proper PPE was not worn during care at Resident #11 PEG site.</p> <p>3.Review of the medical record revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure, Diabetes, Heart Failure, Depression, Anxiety, and OCD.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident # 29 had intact cognition.</p> <p>Observations in the Resident's room on 4/13/2025 at 9:13 AM and 11:11 AM, revealed a blood tinged xeroform, a petroleum-based gauze, on the floor at the foot of the Resident's bed.</p> <p>(continued on next page)</p>		

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

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

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 4/16/2025 at 8:42 AM, the Director of Nursing (DON) confirmed that there should not be bloody gauze on the resident's floor.</p> <p>4. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses including Malignant Neuroleptic Syndrome, Hypertension, and Bipolar.</p> <p>Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #44 had intact cognition.</p> <p>Observation on 4/15/2025 at 9:11 AM, revealed LPN K placed and removed a reusable wristlet blood pressure (bp) machine from the top of the medication cart, entered Resident #44's room, and placed the wristlet bp machine around the resident wrist. LPN K failed to clean the wristlet bp machine before use. LPN K exited the resident's room and failed to clean or disinfect the reusable wristlet bp machine and the top of the med cart before placing it on the medication cart.</p> <p>During an interview on 4/16/2025 at 11:53 AM, the DON confirmed reusable resident care equipment should be disinfected before and after use.</p> <p>5. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Hypertension, Kidney Disease, and Convulsions.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 5, which indicated Resident #50 had moderately impaired cognition.</p> <p>Observation during med pass on 4/13/2025 at 2:44 PM, revealed LPN C put on a gown, gloves and failed to perform hand hygiene, entered Resident #50's room, took the resident's blood pressure removed gloves and failed to perform hand hygiene, exited the resident's room, went to med cart and failed to perform hand hygiene before pulling the residents medications.</p> <p>6. Review of the medical record revealed Resident #61 was admitted to the facility on [DATE], with diagnoses including Gastrostomy Status and Dysphagia</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #61 had intact cognition and had a feeding tube.</p> <p>Review of the Physician's Order dated 3/31/2025, confirmed Resident #61 had an order for Enhanced Barrier Precautions during high contact time secondary to wound.</p> <p>Review of the Physician's Order dated 4/2/2025, Resident #61 had an order for enteral feeding by PEG tube.</p> <p>A random observation on 4/13/2025 at 9:53 AM, revealed RN D had no gown on during Resident # 61's wound care to sacral area.</p> <p>During an interview on 4/13/2025 at 9:58 AM, RN D confirmed there should have been a gown worn during Resident # 61's wound care.</p> <p>(continued on next page)</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>Observation in Resident #61's room on 4/14/2025 at 4:04 PM, LPN H did not perform hand hygiene before pulling medications, placed the med in a bag to crush, put on a gown, applied gloves. LPN H failed to perform hand hygiene before applying gloves. LPN H entered the resident's room, there was soiled linen on the resident's floor. LPN H raised the resident's bed with the bed remote, pulled the privacy curtain. LPN H failed to remove the gloves, perform hand hygiene, and apply clean gloves before the administration of the medication via the PEG site. LPN H rinsed the syringe off with water and failed to let the syringe air dry before placing it back in the plastic sleeve. LPN H pushed a button to restart the feeding with the same gloved hands used to administer the med via the PEG. LPN failed to remove the gloves and perform hand hygiene before touching the enteral feeding machine.</p> <p>During an interview on 4/14/2025 4:26 PM, LPN H confirmed hand hygiene should have been performed before applying gloves, gloves should have been removed and hand hygiene performed to prevent cross contamination and</p> <p>During an interview on 4/14/2025 at 4:29 PM, LPN H confirmed there was dirty linen on Resident #61's floor that should have been placed in a dirty linen barrel and not on the floor. CNA L confirmed she had placed the soiled linen on the resident's floor.</p> <p>7. Review of the medical record revealed Resident #228 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Prostate, and Methicillin Resistant Staphylococcus Aureus Infection.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 12, which indicated Resident # 228 had moderately impaired cognition.</p> <p>During an observation and interview on 4/13/2025 at 9:22 AM, Certified Nurse Assistant (CNA) L confirmed there was soiled linen on Resident #228's floor. CNA L confirmed she placed the soiled linen on the resident's floor.</p> <p>8. Review of the medical record revealed Resident #229 was admitted to the facility on [DATE], with diagnoses including Hypotension and Clostridium Difficile.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #229 had intact cognition.</p> <p>Review of the Physician's Order dated 3/31/2025, confirmed Resident #229 had an order for contact precautions.</p> <p>Review of the Physician's Order dated 4/11/2025, revealed .COVID 19 Positive .Isolate Resident, Novel Respiratory Precautions .every shift for Covid 19 until 04/22/2025 .</p> <p>Observation and interview on 4/13/2025 11:40 AM, revealed Certified Nurse Assistant (CNA) L entered Resident # 229's without a gown on. C NA L confirmed Resident #229 was on contact precautions.</p> <p>During an interview on 4/16/2025 at 8:07 AM, the Director of Nursing (DON) The DON confirmed staff should wear a gown and gloves when providing care for resident's on EBP, and a gown gloves, and mask worn before entering a resident's room who is on contact precautions.</p> <p>(continued on next page)</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>During an interview on 4/16/2025 at 8:41 AM, the DON confirmed that soiled linens should not be left on the resident's floor, and staff should perform hand hygiene before entering a resident's room and exiting a resident's room, before and after med pass, before applying and removing gloves. The DON confirmed after touching potentially contaminated items and before providing care, gloves should be removed and hand hygiene performed.</p> <p>9. Review of the medical record revealed Resident #278 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes with Foot Ulcer, and Peripheral Vascular Disease.</p> <p>Resident #278 was a new admit therefore no MDS was available.</p> <p>Review of the BIMS Temporary Worksheet dated 4/11/2025, revealed a BIMS score of 12, which indicated Resident #278 was moderately cognitively impaired.</p> <p>Review of Order Review History Report dated 4/1/2024-4/14/2025, revealed Resident #278 had an order for Contact Precautions Secondary to Dx: [Diagnosis] MRSA infection every shift.</p> <p>Observation on the 500 Hall on 4/13/2025 at 8:30 AM, revealed CNA B entered Resident #278's with no PPE. There was no signage on the door and no PPE caddy was located on the 500 Hall.</p> <p>Observation in the resident's room on 4/13/2025 at 10:30 AM, LPN A administered medication to Resident #278 with no PPE on.</p> <p>Interview on 4/13/2025 at 3:28 PM, LPN A was asked if Resident #278 should have been on isolation and she stated, yes, he should be on enhanced barrier precautions because he has a Percutaneous endoscopic gastrostomy (PEG) tube and an open wound. LPN A verified there was no signage on the door of Resident #278.</p> <p>During an interview on 4/14/2025 at 1:45 PM, Resident #278 stated .they told me today that I'm on isolation. I wasn't on isolation yesterday when I went to Bingo .I'm planning on going out tomorrow .is this going to keep me from being able to go out? .</p> <p>During an interview on 4/16/2025 at 7:50 AM, LPN P confirmed Resident #278 had an order for contact isolation.</p> <p>During an interview on 4/16/2025 at 8:13 AM, the DON confirmed staff should always have a gown, mask and gloves on prior to entering a contact isolation room.</p> <p>11. Review of medical records revealed Resident #279 was admitted to the facility on [DATE], with diagnoses including Inflammatory Disorder of Scrotum, Acute Respiratory Failure with Hypoxia and Diabetes.</p> <p>Resident #279 was a new admit therefore no MDS was available.</p> <p>Review of the BIMS Temporary Worksheet dated 4/11/2025, revealed a BIMS score of 15, which indicated Resident #279 was cognitively intact.</p> <p>(continued on next page)</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>Review of the Care Plan revealed Resident #279 was .at risk for infection r/t [related to] .open wounds . 4/13/2025 Enhanced Barrier Precautions .during high contact resident care activities secondary to peg and wound .</p> <p>Observation on 4/13/2025 at 8:30 AM, revealed CNA B entering and exiting the room of Resident #279 while doing patient care with no PPE on. There was no Enhanced Barrier signage was on the door of Resident #279 and no PPE caddy was on the 500 Hall.</p> <p>During an interview on 4/13/2025 at 12:30 AM, LPN A verified there was no signage on the door of Resident #279.</p> <p>During an interview on 4/16/2025 at 8:13 AM, the DON confirmed Resident #279 was admitted with a PEG tube and an open wound on 4/8/2025 and the resident should have been placed on enhanced barrier precautions at that time.</p> <p>47127</p> <p>51740</p>		