STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445402	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bedrockhc at Spring Meadows, LLC	220 Highway 76 Clarksville, TN 37043

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49269 Based on policy review, observation, and interview, the facility failed to provide effective maintenance services to ensure a safe, functional, and comfortable environment as evidenced by the disrepair of the bathroom flooring for 1 out of 104 occupied resident's rooms. The findings include: 1. Review of the facility's policy, titled, Preventive Maintenance, with a date of 3/1/2023, revealed, .A Preventive Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environmental for residents, staff, and the public .The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a sage and operable manner . 2. Observations and interview in the resident's room on 7/08/2024 at 11:20 AM, 7/09/2024 at 8:00 AM, and on 7/09/2024 at 3:33 PM, revealed in Resident #17's bathroom was a large area of missing pieces of linoleum in multiple places around the resident's toilet. Resident #17 confirmed the bathroom floor has been that way for the past 3 years. 3. During an interview on 7/10/2024 at 12:57 PM, Certified Nursing Assistant (CNA M) was asked if she had noticed any issues in Resident #17's bathroom. CNA M stated, .the flooring had been like that since she was hired over a year ago . During an interview on 7/10/2024 at 1:48 PM, Licensed Practical Nurse (LPN N) was taken into Resident #17's bathroom and asked if she noticed anything about the bathroom that would warrant concerns. LPN N stated, .Yes, the floor needs to be fixed [repaired] . LPN N was asked if the missing linoleum was a fall risk for the resident. LPN N confirmed that it was a fall risk and that she would notify maintenance. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/10/2204 at 2:38 PM, the Maintenance Director and the Maintenance Assistant were asked if they were aware of any concerns or issues with Resident #17's bathroom flooring. The Maintenance Director confirmed that he was initially made aware of Resident #17's bathroom flooring over a year ago but could not recall the exact date. The Maintenance Director was asked should it have been repaired. The Maintenance Director stated that he needs to check to make sure that linoleum can be used to replace the flooring in the facility. The Maintenance Director was asked what the next step would be once he finds out what flooring can be used. The Maintenance Director confirmed that he would find the flooring on (named online retail). During an interview on 7/11/2024 at 6:09 PM, The Administrator was asked the process of reporting repairs in the facility. The Administrator stated that staff would immediately enter a ticket for repair in computerized repair system for maintenance. The Administrator was asked how long it should take for maintenance to address those repairs. The Administrator confirmed that it depends on the repair, but most should be addressed immediately. The Administrator was asked if it should take a year to complete a repair on a bathroom floor. The Administrator stated, .No, that should have been addressed prior to 1 year .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49269 Based on review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, medical record review, and interview, the facility failed to complete resident assessments, using the Centers for Medicare & Medicaid Services-specific RAI (Resident Assessment Instrument) process, within the regulatory time frames for 7 of 28 sampled residents (Resident #5, #17, #22, #48, #76, #86, and #93) reviewed for completion of the MDS resident assessments. The findings include: 1. Review of the MDS 3.0 RAI Manual v (version) 1.17.1 October 2019, page 2-37 revealed .using the Centers for Medicare & Medicaid Services-specific RAI process within the regulatory time frames. 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Depression, and Polyneuropathy. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/7/2022, revealed Item Z0500B with a completion date of 11/23/2022. The quarterly assessment should have been completed by 11/21/2022. 3. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Stroke, Coronary Artery Disease, Hypertension, Diabetes, Dementia, Hemiplegia, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) with an ARD of 1/18/2023, revealed Item Z0500B with a completion date of 12/7/2023. The quarterly assessment should have been completed by 12/2/2023. 4. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Cerebral Infarction, Dysphagia, Depression, and Anxiety. Review of the quarterly MDS with an ARD of 7/14/2023, revealed Item Z0500B with a completion date of 8/1/2023. The quarterly assessment should have been completed by 7/28/2023. 5. Review of the medical record revealed Resident #48 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, Acute Kidney Failure, Depression, and Anxiety. Review of the admission MDS with an ARD of 2/3/2023, revealed Item Z0500B with a completion date of 2/22/2023. The admission assessment should have been completed by 2/10/2023. 6. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE], with diagnoses including Diabetes, Coronary Artery Disease, Hypertension, Depression, and Anxiety. Review of the admission MDS with an ARD of 4/14/2023, revealed Item Z0400I with sections A0050 and A0700X completed on 8/28/2023. The admission assessment should have been completed by 4/21/2023. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. Review of the medical record revealed Resident #86 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, Depression, Anxiety, and Spinal Stenosis. Review of the Admission MDS with an ARD 1/16/2023, revealed Item Z0500B with a completion date 2/2/2023. The admission MDS should have been completed by 1/30/2023. 8. Review of the medical record revealed Resident #93 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Diabetes, Quadriplegia, Dementia, and Hypertension. Review of the admission MDS with an ARD 7/15/2023, revealed Item Z0500B with a completion date of 7/26/2023. The admission MDS should have been completed by 7/22/2023. During an interview on 7/11/2024 at 3:50 PM, the MDS Coordinator was asked about the timeliness of completion of the MDS resident assessments. The MDS Coordinator confirmed that the assessments were completed and transmitted late. The MDS Coordinator confirmed that the Director of Nursing (DON) is responsible for ensuring that MDS resident assessments are completed in a timely manner. During an interview on 7/11/2024 at 6:09 PM, the Administrator was asked who is responsible for ensuring that MDS resident assessments are completed in a timely manner. The Administrator confirmed that the MDS Coordinators are responsible for completing all resident assessments in a timely manner and the Administrator is ultimately responsible with ensuring that the assessments are done timely.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909 Based on policy review, medical record review and interview, the facility failed to ensure a care plan meeting was scheduled for 2 of 2 (Resident #8 and #23) reviewed for care plan meeting. The findings include: 1. Review of the facility's undated policy titled CARE PLANNING - RESIDENT PARTICIPATION, revealed . The facility supports the resident's right to inform of, and participate in, his or her care planning and treatment .The facility will notify the resident and/or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as changes to the plan of care . 2. Medical record review revealed Resident #8 was admitted [DATE], with diagnoses including Dementia, Depression, Diabetes, Anxiety, and Bipolar Disorder. Review of quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #8 was cognitively intact. During an interview on 7/9/2024 11:20 AM, Resident #8 was asked if she attended the care plan meetings. Resident #8 stated, .No, I don't think so .that would be good to have . During an interview on 7/11/2024 at 8:34 AM, with Licensed Practical Nurse (LPN) Minimum Data Set (MDS) Coordinator was asked about the process for conducting a care plan meeting. The LPN MDS Coordinator stated, .We send an invitation out quarterly .Residents are supposed to be part of that meeting especially if they are alert and oriented . The LPN MDS Coordinator confirmed Resident #8 should have had an interdisciplinary team (IDT) care plan meeting on 11/17/2023, 3/1/2024, and on 5/17/2024, and confirmed there was no documentation the care plan conference meetings were conducted. 3. Medical record review revealed Resident #23 was admitted on [DATE], with diagnoses including Cerebral Infarction, Hemiplegia, Diabetes, Fibromyalgia and Degenerative Bone Disease. Review of quarterly assessment dated [DATE], revealed Resident #23 was cognitively intact. During an Interview on 7/11/2024 at 9:36 AM, the MDS Coordinator was asked if the facility documented the IDT care plan meetings. The MDS Coordinator stated, .the invitations are provided to families .but there's no documentation of care plan meetings, not that I see in the medical record . The MDS Coordinator confirmed Resident #23 should have had an IDT care plan meeting on 12/27/2023 and 3/22/2024, and if it's not documented it was not completed. The facility failed to provide documentation of care plan meetings for Resident #8 and Resident #23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 2:35 PM, with the Director of Nursing (DON) was asked how often the IDT care plan meetings should be carried out with the residents. The DON stated.Social Services and admission do this quarterly .we send out requests to the families .I personally am not involved in this [care plan meetings] .the staff involved .MDS .Social Services .Activity Director .Dietary . and at times the [Named] Unit Manager .Therapy . The DON was asked should the IDT care plan conference meetings be documented. The DON stated, Yes .we don't have the documentation of the interdisciplinary team [IDT] meetings .the residents should be involved in the meetings .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on medical record review, observation, and interview, the facility failed to ensure followed practitioner orders for a Percutaneous Gastrostomy (PEG) tube feeding and failed to date and label PEG tube feedings for 1 of 2 (Resident #63) sampled residents reviewed for enteral feedings. The findings include: Review of the medical record revealed Resident #63 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Depression, Anxiety, and PEG tube (Percutaneous Endoscopic Gastrostomy tube, a tube inserted into the stomach to deliver food). Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #63 was severely cognitively impaired, total dependence on staff for Activities of Daily Living, and coded for a PEG tube. Review of the facility's Order Review History Report. dated 6/11/2024 - 7/11/2024 revealed, .Enteral Feed Order six times a day Free water flushes 150 ml [milliliters] Q [every] 4H [hours], provides 900 total fluid . Enteral Feed Order every shift PEG. Jevity 1.5 .@ [at] 60ml [milliliters] x [times] 22hrs [hours] .Enteral Feed Order every shift Flush with 15cc [cubic centimeters] of water before and after each medication .Enteral Feed Order .every shift Check tube placement by gastric aspiration of contents, return contents, if residual > [greater than] 100 cc hold feed x 1 hour, recheck contents, if remains >100cc notify provider .Change tube feed administration set/bag (.with Flush Bag) every 24hrs every night shift . Observation in the resident's room on 7/8/2024 at 11:10 AM, 7/9/2024 at 3:30 PM, and on 7/9/2024 at 4:42 PM, revealed Resident #63 had an undated and untimed enteral feeding bag via pump at 60 ml/hr. Observation during medication administration on the New Wing medication cart on 7/9/2024 at 4:42 PM, revealed LPN O gathered medication and supplies and entered Resident #63's room. LPN O filled a plastic cup with water from the resident's bathroom, removed the syringe from the plastic sleeve, flushed the resident's Peg tube with 15 ml of water, administered the medications, flushed the Peg tube with 15 ml of water, and placed the syringe back into the plastic sleeve. LPN Q failed to check placement and check the PEG tube residual before administering medication, ad failed to clean, rinse and dry the syringe before storage. Observation during medication administration on the New Wing medication cart on 7/10/24 at 4:25 PM, revealed LPN Q gathered her medication and supplies and entered Resident #63's room, checked the PEG tube residual, checked the PEG tube placement, and attempted to administer the first cup of medication per gravity. LPN Q replaced the plunger and gently pushed the medications through the Peg tube with the plunger. LPN Q administered the second medication and the third medication and failed to flush with 15 ml of water between each medication. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/24 at 2:17 PM, the Director of Nursing (DON) confirmed that nursing staff should put a date and time on the enteral feeding bottle/bag and the automatic water flush bag set when it is hung and started. The DON was asked when should nursing staff flush the PEG tube when administering medications. The DON confirmed that the nursing staff should follow physician orders for flush when administering medications to residents with PEG tubes before and after medications. The DON was asked what should nursing staff do prior to administering medications via PEG tube. The DON confirmed that nursing staff should check residual and placement prior to administering medications via PEG tube.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices for 1 of 2 (Resident #20) residents reviewed for isolation precaution. The facility had a census of 107. The findings include: 1. Review of the facility's policy titled, Transmission Based (Isolation) Precautions, dated 6/4/2024, revealed, Signage that includes instructions for use of specific PPE [personal protective equipment] will be placed in a conspicuous location outside of the resident's- room .either the CDC [Centers for Disease Control] category of transmission-based precautions .contact, droplet, or airborne .or instructions to see the nurse before entering will be included in the signage .Contact Precautions .Intended to prevent transmission of pathogens that are spread by direct or indirect contact with the resident or the resident's environment . Review of the facility's undated policy titled, Recommendations for Personal Protective Equipment (PPE), revealed, .Infection/Conditions .Multidrug-resident organisms (MDROs) infection or colonization .ESBL [Extended-spectrum beta lactamases] .Contact-Precautions recommended in settings with evidence of ongoing transmission or in settings with increased risk for transmission . Review of the CDC Long Term Care Facility Frequent Asked Questions, dated 6/28/2024, revealed .What are the differences between Enhanced Barrier Precautions and Contact Precautions .Contact Precautions require the use of gown and gloves on every entry into a resident's room, regardless of the level of care being provided to the resident. The resident is given dedicated equipment (.stethoscope and blood pressure cuff) and is placed in a private room. When private rooms are not available, some residents (.residents with the same pathogen) may be roomed together. Residents on Contact Precautions are recommended to be restricted to their rooms except for medically necessary care, including restriction from participation in group activities. Contact Precautions are generally intended to be time limited and, when implemented, should include a plan for discontinuation or de-escalation . 2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Hypertension, Cognitive Communication Deficit, and Overactive Bladder. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #20 had a Brief Interview for Mental Status score of 13, indicating the resident was cognitively intact, and dependent on staff for Activity of Daily living (ADLS). Review of the [named laboratory] report dated 7/3/2024 revealed, .Escherichia coli [bacteria normally live in the intestines] . Review of a Physician's Order dated 7/4/2024 revealed, .Contact isolation (ESBL in urine) .every shift until 07/11/2024 .Active .7/4/2024 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Care Plan updated 7/8/2024 revealed, .Actual infection r/t [related to] ESBL [Extended-Spectrum Beta-Lactamase] urine .7/8/2024 .Encourage fluids unless contraindicated .Follow contact precautions . Observation in the resident's room on 7/9/2024 at 3:35 PM and on 7/10/2024 at 8:36 AM, revealed Resident #20 was in Enhanced Barrier Precaution with a signage posted on wall outside of door. Resident #20 had no biohazard barrels in the room for infectious waste and linen. Resident #20 was out of her room in the dining room. There was no evidence Resident #20 was in contact isolation. Review of the facility's Order Summary Report, dated 7/10/2024 revealed, .Contact Isolation (ESBL in urine) . During an interview in the North Hall at the medication cart on 7/10/24 8:43 AM, Licensed Practical Nurse (LPN R), confirmed that Resident #20 was not in Contact Isolation, but her roommate was the resident in Enhanced Barrier Precaution for a wound. During an interview on 7/10/24 at 1:48 PM, the Director of Nursing (DON) confirmed that Resident #20 has orders for Contact Isolation for ESBL in her urine, requires incontinent care and wears a brief. The DON confirmed that Contact Isolation and Enhanced Barrier are not the same precautions. The DON confirmed that the nursing staff should follow physician orders for contact isolation. During a continued interview and observation on 7/10/24 at 1:57 PM, outside of Resident #20's room, the DON confirmed that the Enhanced Barrier sign on the wall is the incorrect sign and that the sign should be for Contact Isolation. During a continued interview on 7/10/24 at 2:19 PM, the DON was asked how a brief should be disposed of if a resident is in Contact Isolation. The DON confirmed the disposable briefs should be disposed of in biohazardous waste containers within the resident's room. The DON confirmed that any resident in Transmission-Based Precautions should have barrels in their rooms for the disposal of both hazardous waste and trash.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 46047 Based on review of staff in-services and interview the facility failed to ensure the mandatory annual 12 hours of in-services were provided for the Certified Nursing Assistant (CNA) for 12 of 61 staff members (CNA A, B, C, D, E, F, G, H, I, J, K, and L reviewed for in-servicing training. The findings include: 1. Review of the facility's policy titled, CNA REQUIRED TRAINING, dated 3/1/2023, revealed It is the policy of this facility to comply with State and Federal requirements as they pertain to the training, certification, and continuing education if its nurse aides .The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year .Documentation of the in-services will be forwarded to the HR [Human Resource] Director . 2. Review of a list of CNA staff provided by the facility revealed the following: CNA A was hired on 11/30/2022. CNA B was hired on 1/12/2022. CNA C was hired on 9/4/2013. CNA D was hired on 7/22/2020. CNA E was hired on 2/14/2018. CNA F was hired on 6/30/2020. CNA G was hired on 2/3/2021. CNA H was hired on 3/9/2022. CNA I was hired on 8/5/2020. CNA J was hired on 6/4/2008. CNA K was hired on 2/15/2017. CNA L was hired on 7/1/2011. The facility was unable to provide documentation of 12 hours of required in-service training for CNA's A, B, C, D, E, F, G, H, I, J, K, L for the past 12 months. During an interview on the Human Resources Director confirmed CNA A, B, C, D, E, F, G, H, I, J, K, and L did not have the annual 12 hours of CNA in-services. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/11/2024 at 3:40 PM, the Administrator was asked about the required CNA in-services for CNAs employed over one year. The Administrator stated, .They should have 12 hours of in-services each year from hire date anniversary to hire date .