

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/17/2025
NAME OF PROVIDER OR SUPPLIER  Soddy-Daisy Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  701 Sequoyah Road Soddy-Daisy, TN 37379	

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 - Some	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.  (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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, observation, and interview, the facility failed to maintain privacy curtains in a clean and sanitary condition, failed to maintain resident rooms in good repair, and in a homelike condition for 12 rooms (Rooms #209, #210, #212, #119, #121, #120, #123, #124, #127, #125, #126, and #128) of 71 rooms observed for homelike condition. The findings include: Review of the facility policy titled, Maintenance Service, 12/2009, revealed .Maintenance service shall be provided to all areas of the building, grounds, and equipment.Functions of maintenance personnel include.Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines.Maintaining the building in good repair.Establishing priorities in providing repair service.Providing routinely scheduled maintenance services to all areas.The Maintenance Director is responsible for maintaining the following records/reports.Inspection of building. Review of the facility policy titled, Safe and Homelike Environment, dated 6/1/2025, revealed .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and home environment.Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.Report any unresolved environmental concerns to the Administrator. Review of the facility policy titled, Routine Cleaning and Disinfection, dated 6/1/2025, revealed .It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.Cleaning refers to the removal of visible soil from objects and surfaces and is normally accomplished manually or mechanically using water and detergents or enzymatic products.Consistent surface cleaning and disinfection will be conducted with a detailed focus on high touch areas.Cleaning of walls.window curtain will be conducted when visibly soiled. Privacy curtains in resident rooms will be changed when visibly dirty by laundering or cleaning with and EPA [Environmental Protection Agency] registered disinfectant. Review of an undated facility policy titled, CLEANING PRIVACY CURTAINS, revealed, .Privacy Curtains.should be changed with every Detailed Cleaning or as needed. During an observation on 9/29/2025 at 12:00 PM, revealed resident room [ROOM NUMBER] with scuff marks, torn sheet rock, and missing paint on the walls. Continued observation revealed loose baseboard peeling from the wall. During an observation on 9/29/2025 at 12:05 PM, revealed resident room [ROOM NUMBER] with torn sheet rock and missing paint on the walls. During an observation on 9/29/2025 at 12:10 PM, revealed resident room [ROOM NUMBER] with torn sheet rock and missing paint on the walls. During an interview on 9/29/2025 at 12:50 PM, the Maintenance Director stated, the facility attempted to make needed repairs to 2-3 resident rooms per month but could vary depending on .what was going on in the facility. and the number could be more or less. Continued interview revealed there was no written plan for needed room repairs and repairs were made as needed. During an interview on 9/29/2025 at 1:09 PM, the Administrator stated the facility was not currently working on any performance improvement plans (PIPS). During an observation of a shared resident room [ROOM NUMBER]-A on 9/29/2025 at 2:35 PM, revealed dark scuff marks on the wall beside and at the foot of the bed. During an observation of a shared resident room [ROOM NUMBER]-B on 9/29/2025 at 2:36 PM, revealed chipped dry wall and paint on the wall at the foot of the bed. During an observation of a shared empty resident room [ROOM NUMBER]-A on 9/29/2025 at 2:38 PM, revealed chipped plaster and missing paint behind the bedside table near the head of the bed. During an observation of a shared resident room [ROOM NUMBER]-B on 9/29/2025 at 2:40 PM, revealed missing trim on the bathroom sink and several scuffed areas on the door of the room. Continued observation revealed chipped dry wall and missing paint on the wall at the foot of the bed. During an observation of a shared resident room [ROOM NUMBER]-A on 9/29/2025 at 2:42 PM, revealed the privacy curtain was scattered with an unknown brown substance. Continued observation revealed the wall at the head of the bed had scuffed walls with missing paint. The wall at the foot of the bed contained black markings, chips in the drywall, and missing paint. During an observation of a shared resident room [ROOM NUMBER]-B on 9/29/2025 at 2:43 PM, revealed the privacy curtain was scattered with an unknown brown substance. Continued observation revealed the wall at the head of the bed with missing paint, the closet trim was noted with chipped wood, the wall at the foot of the bed with chipped dry wall and missing paint. Further review revealed the shared bathroom of 120 was noted with black scuffs on the wall, chipped and missing paint, and trim missing from the bathroom counter. During an interview on 9/29/2025 at 2:45 PM, a family visitor of room [ROOM NUMBER] stated the condition of the room and bathroom had been in a bad</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment after a fall for 1 resident (Resident #8) of 3 residents reviewed for falls. The findings include:Review of the facility policy titled, RAI [Resident Assessment Instrument] - MDS [Minimum Data Set] 3.0 Completion, dated 3/2025, revealed .Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan.According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.Review of medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Alzheimer's Disease, Dementia with Behaviors, Diabetes, Osteoarthritis, Chronic pain, Dysphagia, and Muscle weakness.Review of the event note for Resident #8 dated 9/4/2025 revealed .unwitnessed fall and obtained head injury .Review of the quarterly MDS assessment for Resident #8 dated 9/12/2025, revealed the fall which had occurred on 9/4/2025 had not been identified and documented on the 9/12/2025 MDS assessment. Continued review revealed the resident had not had any falls.During an interview on 10/1/2025 at 10:55 AM, MDS Coordinator E confirmed Resident #8 had a fall on 9/4/2025 and the MDS assessment for a fall had not been documented on the 9/12/2025 MDS assessment .I must have overlooked it.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, medical record review, observation, and interview, the facility failed to implement the care plan related to fall interventions for 1 resident (Resident #8) of 19 residents reviewed for care plans. The findings include: Review of the facility policy titled, Comprehensive Care Plans, dated 3/3/2025, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, physical, mental, and psychosocial needs. The care planning process will include an assessment of the resident's strengths and needs. The comprehensive care plan will describe, at a minimum, the following. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident specific interventions that reflect the resident's needs, as indicated. Review of the facility policy titled, Falls, dated 6/2025, revealed .[Facility] strives to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measure. Care plan interventions should be implemented that address the resident's risk factors. Should the Resident experience a fall the attending nurse shall complete a post fall assessment. interventions to reduce risk of repeat episode and a review by the IDT [Interdisciplinary Team] to evaluate thoroughness of the investigation and appropriateness of the interventions. The resident care plan should be updated to reflect, any new or change in interventions. Review of medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Alzheimer's Disease, Dementia with Behaviors, Diabetes, Osteoarthritis, Chronic pain, Dysphagia, Muscle weakness. Review of the comprehensive care plan for Resident #8 dated 9/19/2025, revealed the resident was at risk for falls due to weakness and unstable mobility. Continued review revealed on 9/26/2023 the fall intervention included low bed as the resident will allow and on 8/12/2024 the fall intervention included bilateral fall mats to bedside related to resident having multiple attempts of getting out of bed without assistance. During an observation in Resident #8's room on 9/29/2025 at 12:19 PM revealed Resident #8 lying in bed with no fall mats in the floor at the bedside. Continued observation revealed the resident's bed was not positioned in the lowest position. During an observation in Resident #8's room on 9/30/2025 at 8:21 AM revealed Resident #8 lying in bed with no fall mats in the floor at the bedside. Continued observation revealed the resident's bed was not positioned in the lowest position. During an observation in Resident #8's room on 10/1/2025 at 7:44 AM revealed Resident #8 lying in bed with no fall mats in the floor at the bedside. Continued observation revealed the resident's bed was not positioned in the lowest position. During an interview on 10/1/2025 at 7:49 AM, the Wound Care Nurse) stated she was not aware of Resident #8's fall interventions and could not recall the last time fall mats were observed in the resident's room. During an observation and interview on 10/1/2025 at 10:29 AM, the Director of Nursing (DON) confirmed Resident #8 did not have bilateral fall mats at the bedside and the facility failed to implement the care plan related to fall interventions for Resident #8.</p>		

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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** Based on review of facility policy, review of the medical record, observation, and interview, the facility failed to revise a comprehensive care plan for fall interventions for 1 resident (Resident #8) of 19 residents reviewed for care plans. The findings include: Review of the facility policy titled, Comprehensive Care Plans, dated 3/3/2025. It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, to meet a resident's medical, physical, mental, and psychosocial needs. The care planning process will include an assessment of the resident's strengths and needs. The comprehensive care plan will describe, at a minimum, the following. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Resident specific interventions that reflect the resident's needs, as indicated. Review of the facility policy titled, Falls, dated 6/2025, revealed. [Facility] strives to maintain a hazard free environment, mitigate fall risk factors, and implement preventative measure. Care plan interventions should be implemented that address the resident's risk factors. Should the Resident experience a fall the attending nurse shall complete a post fall assessment. interventions to reduce risk of repeat episode and a review by the IDT [Interdisciplinary Team] to evaluate thoroughness of the investigation and appropriateness of the interventions. The resident care plan should be updated to reflect, any new or change in interventions. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Alzheimer's Disease, Dementia with Behaviors, Diabetes, Osteoarthritis, Chronic pain, Dysphagia, and Muscle weakness. Review of the physician encounter note dated 9/5/2025, revealed. Continue to keep wheelchair seat in lowest position with anti-rollback lock in place. Review of an Occupational Therapy Treatment Encounter Note dated 9/8/2025, revealed. looked at wheelchair needs to be dumped to 30 degrees for safety and prevent falls. Review of the physician encounter note dated 9/11/2025, revealed. Continue to keep wheelchair seat in lowest position with anti-rollback lock in place. Review of the comprehensive care plan for Resident #8 dated 9/19/2025, revealed the resident was at risk for falls due to weakness and unstable mobility. Continued review revealed the fall intervention of anti-rollbacks for the wheelchair, bolster mattress, and reclined seat of wheelchair was not revised on the care plan. During an observation on 9/29/2025 at 12:19 PM, revealed the resident way lying in a bolster bed. The resident's wheelchair was observed with anti-roll back devices and the wheelchair was noted to have a seat which was slightly tilted back. During an observation on 9/30/2025 at 8:21 AM revealed the resident way lying in a bolster bed. The resident's wheelchair was observed with anti-roll back devices and the wheelchair was noted to have a seat which was slightly tilted back. During an observation on 10/1/2025 at 7:44 AM; 10:04 AM, and 10:29 AM, revealed the resident way lying in a bolster bed. The resident's wheelchair was observed with anti-roll back devices and the wheelchair was noted to have a seat which was slightly tilted back. During an observation and interview on 10/1/2025 at 10:29 AM, the Director of Nursing (DON) confirmed the Resident #8 had anti-rollbacks to the wheelchair, the wheelchair seat was lowered, and the resident had a bolster mattress. The DON further confirmed the facility failed to revise the comprehensive care plan for the anti-roll back devices on the wheelchair, the tilted wheelchair seat, and the bolster bed for Resident #8.		

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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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on review of facility policy, medical record review, and interview, the facility failed to accurately complete a Medication Administration Record (MAR) for 1 resident (Resident #8) of 6 residents review for MAR documentation. The findings include: Review of the facility policy titled, Documentation in Medical Record, dated 7/1/2025, revealed .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Principles of documentation include, but are not limited to. Documentation shall be factual, objective, and resident centered. False information shall not be documented. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. Documentation shall be accurate, relevant, and complete. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Cerebral Infarction, Alzheimer's Disease, Dementia with Behaviors, Diabetes, Osteoarthritis, Chronic pain, Dysphagia, and Muscle weakness. Review of the Physician's Orders for Resident #8 dated 8/12/2024 , revealed .Check placement of fall mats to Bilateral bedside every shift. Review of the comprehensive care plan for Resident #8 dated 9/19/2025, revealed the resident was at risk for falls due to weakness and unstable mobility. Continued review revealed a fall intervention which included bilateral fall mats. Review of the MAR for Resident #8 dated 7/1/2025-7/31/2025, revealed .Check placement of fall mats to Bilateral bedside every shift. the MARS had been signed off by a nurse the fall mats were in place for all day shifts and all night shifts. Review of the MAR for Resident #8 dated 8/1/2025-8/30/2025, revealed .Check placement of fall mats to Bilateral bedside every shift. the MARS had been signed off by a nurse the fall mats were in place for all day shifts and all night shifts. Review of the MAR for Resident #8 dated 9/1/2025-9/30/2025, revealed .Check placement of fall mats to Bilateral bedside every shift. the MARS had been signed off by a nurse the fall mats were in place for all day shifts and all night shifts. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. During an observation on 9/29/2025 at 12:19 PM, revealed Resident #8 lying in bed with no fall mats present. During an observation on 9/30/2025 at 8:21 AM, revealed Resident #8 lying in bed with no fall mats present. During an observation on 10/1/2025 at 7:44 AM, revealed Resident #8 lying in bed with no fall mats present. During an interview on 9/30/2025 at 3:08 PM, Environmental Services Staff stated she had been employed at the facility for approximately 2 months. EVS Staff F stated she had cleaned Resident #8's room several times (daily when she worked) and had not observed floor mats in place. During an interview on 10/1/2025 at 7:45 AM, Certified Nursing Assistant (CNA) B stated she had been employed with the facility for several months .maybe a year. and had not observed floor mats at Resident #8's bedside. During an interview on 10/1/2025 at 10:23 AM, Licensed Practical Nurse (LPN) A stated Resident #8 had bilateral fall mats listed as a fall intervention on the resident's care plan and .looks like they have been in place for a while. LPN A stated she had signed the MARs for the past several months the bilateral fall mats had been in place. LPN A further stated she could not recall observing the fall mats this morning (10/1/2025). During an interview on 10/1/2025 at 10:29 AM, the Director of Nursing (DON) confirmed Resident #8 did not have bilateral fall mats in place in Resident #8s room and the facility had failed to accurately document on the resident's medical record.</p>		