| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445411 | A. Building<br>B. Wing | 08/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Applingwood Post Acute | 1536 Appling Care Lane<br>Cordova, TN 38018 |

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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>(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 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure Activities of Daily Living (ADL) assistance was provided related to showering and personal hygiene care for 2 of 2 (Resident #10 and #60) sampled residents reviewed for ADLs. The findings include: 1. Review of the undated facility policy titled, Activities of Daily Living (ADL) ., revealed .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene . 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Renal Dialysis, and Acute Kidney Failure. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated Resident #10 was cognitively intact, and required maximal assistance from staff for personal hygiene. Review of the Care Plan dated 6/3/2025, revealed Resident #10 had impaired visual function r/t [related to] blindness. Observations in Resident #10's room on 8/4/2025 at 10:40 AM and 3:37 PM, revealed Resident #10 had excessive facial hair growth to her chin, upper lip, and face. Resident #10's fingers had dark discolored areas with the appearance of dirt, underneath the nails. During an interview on 8/5/2025 at 3:28 PM, Resident #10 stated, They gave me a shower last night and cut my fingernails. During an interview on 8/5/2025 at 3:45 PM, the Director of Nursing (DON) was asked should a female resident have a large growth of facial hair to her face. The DON stated, No, Ma'am, faces should be shaved and clean. The DON was asked should residents have dirty fingernails. The DON stated, No, they should be clipped and clean. 3. Review of medical record revealed Resident #60 was admitted to the facility on [DATE], with diagnoses including Parkinsons and Hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #60 was cognitively intact. Resident #60 required partial assistance from staff to complete all activities of daily living. Review of the Care Plan dated 7/22/2025, revealed .has an ADL self-care performance deficit and is at risk for ADL decline r/t limited mobility . Review of the undated Shower List Day Shift, revealed Resident #60 should be getting showers on Tuesdays, Thursdays, and Saturdays. Review of the Documentation Survey Report, dated July 2025, revealed Resident #60 did not get a shower on the following scheduled shower days: 7/24/2025, 7/29/2025, 7/31/2025, and 8/2/2025. Review of the Documentation Survey Report, dated July 2025, revealed Resident #60 received a bed bath on 7/25/2025, 7/29/2025, 7/30/2025, and 7/31/2025. Review of the Documentation Survey Report, dated August 2025, revealed Resident #60 received a bed bath on 8/2/2025, 8/3/2025, and received a shower on 8/4/2025. During a telephone interview on 8/5/2025 at 3:12 PM, Resident #60's wife stated that he received a shower on 7/26/2025 and 8/4/2025 and those are the only showers the Resident has had since admission to the facility. Resident #60's wife stated that the Resident's teeth have not been brushed since 7/26/2025. During an interview on 8/5/2025 at 3:29 PM, Resident #60 stated that his teeth hadn't been brushed, and he had only had a shower on 7/26/2025 and 8/4/2025. Resident stated that he would like a shower on his scheduled days, and he would like for his teeth to be brushed every day. Observation in Resident #60's bathroom on 8/5/2025 at 3:30 PM, revealed there was not a toothbrush or toothpaste in the bathroom. During an interview on 8/5/2025 at 3:40 PM, the DON was asked if the shower schedule should be followed. The DON stated, Yes. The DON was asked if a Resident's teeth should be brushed daily. DON stated, Yes. |

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|---|---|
| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to follow physician orders and failed to ensure that residents received treatments and medications in accordance with professional standards of practice for 4 of 36 (Resident #5, #8, #15, and #18) sampled residents. The findings include: 1. Review of the facility policy titled, Medication and Treatment Orders, dated July 2016, revealed .Medications shall be administered upon the written order . Review of the facility policy titled, Charting and Documentation, dated July 2017, revealed .The following information is to be documented in the resident medical record: Medications administered .Treatments or services performed .the date and time the procedure/treatment was provided . 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Fracture of Upper End of Left Tibia, Fracture of Shaft of Left Fibula, Lupus, Hypertension and Hyperlipidemia. Review of the Physician's Order dated 6/23/3025, revealed Carvedilol [used to treat high blood pressure] Oral Tablet 6.25 MG [milligram].two times a day. Review of the Medication Administration Record (MAR) dated 6/2025, revealed there was no documentation of administration of Carvedilol at 9:00 PM on 6/24/2025 and 6/27/2025 for Resident #5. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Carvedilol at 9:00 AM on 7/16/2025 and at 9:00 PM on 7/2/2025, 7/3/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, and 7/26/2025 for Resident #5. Review of the Physician's Order dated 6/23/2024, revealed .Furosemide [used to treat conditions involving excessive fluid retention] Oral Tablet 40 MG.one time a day. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Furosemide on 7/16/2025 for Resident #5. Review of the Physician's Order dated 6/23/2025, revealed .levETIRAcetam [used to help control seizures] Oral Tablet 750 MG.one time a day. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Levetiracetam on 7/16/2025 for Resident #5. Review of the Physician's Order dated 6/23/2025, revealed .Losartan Potassium [used to treat high blood pressure] Oral Tablet 25 MG.one time a day. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Losartan on 7/16/2025 for Resident #5. Review of the Physician's Order dated 6/23/2025, revealed .Rosuvastatin Calcium [used to manage cholesterol] Oral Tablet 20 MG.at bedtime. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Rosuvastatin Calcium on 7/2/2025, 7/3/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, and 7/26/2025 for Resident #5. Review of the Physician's Order dated 6/23/2025, revealed .Senna [used to treat constipation] Oral Tablet 8.6 MG.at bedtime. Review of the MAR dated 7/2025, revealed there was no documentation of the administration of Senna on 7/2/2025 and 7/3/2025. Review of the Physician's Order dated 6/24/2025, revealed .Docusate Sodium [stool softener] Oral Capsule 100 MG.two times a day. Review of the MAR dated 6/2025, revealed there was no documentation of the administration of Docusate Sodium at 9:00 PM on 6/28/2025 for Resident #5. Review of the MAR dated 7/2025, revealed no documentation of the administration of Docusate Sodium at 9:00 AM on 7/16/2025 and at 9:00 PM on 7/2/2025, 7/3/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, and 7/26/2025 for Resident #5. Review of the Physician's Order dated 6/24/2025, revealed . SWALLOWING/NUTRITIONAL .DATA COLLECTION.every shift. Review of the Treatment Administration Record (TAR) dated 6/2025, revealed there was no documentation for monitoring Swallowing/nutritional collection for 6:00 PM shift on 6/24/2025 and 6/27/2025 for Resident #5. Review of the Physician's Order dated 6/24/2025, revealed .Record Intake & Output.every shift. Review of the TAR dated 6/2025, revealed there was no documentation for recording Resident #5's intake and output for the 6:00 PM shift on 6/24/2025 for Resident #5. Review of the Physician's Order dated 6/24/2025, revealed .Assess pain level Q [every] shift. Review of the MAR and TAR dated 6/2025, revealed there was no documentation that Resident #5's pain level was assessed for the 6:00 PM shift on 6/24/2025, 6/27/2025, and 6/28/2025 for Resident #5. Review of the TAR dated 7/2025, revealed there was no documentation that Resident #5's pain level was assessed for the 6:00 AM shift on 7/3/2025, 7/12/2025, 7/16/2025, 7/17/2025, and 7/31/2025; and on the 6:00 PM shift on 7/2/2025, 7/3/2025, 7/11/2025, 7/12/2025, 7/13/2025, 7/14/2025, 7/16/2025, 7/17/2025 and 7/26/2025 for Resident #5. Review of the Physician's Order dated 6/24/2025, revealed . Notify MD [Medical Doctor] if the patient has ANY of the following symptoms: 1. Temperature < [less than] 96.8 or > [greater than] 99F [Fahrenheit] 2. Heart Rate > 90 BPM [Beats Per Minute] 3. Respiratory Rate > 20 4. Acute Change in Mental Status 5. 02 [Oxygen] Sat [Saturation] of < 90% [percent] 6. Systolic [the force of blood |

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| | 445411 | A. Building<br>B. Wing | 08/12/2025 |

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| Applingwood Post Acute | 1536 Appling Care Lane<br>Cordova, TN 38018 |

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| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>(continued on next page) |

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|---|---|
| F 0686<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, hospital record review, and interview, the facility failed to ensure residents received the necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new ulcers from developing, failed to initiate wound treatments when a wound was identified on admission, failed to complete skin assessments on residents, and failed to administer wound treatments for residents determined to be at risk of skin breakdown for 3 of 4 (Resident #8, #70 and #80) sampled residents reviewed for pressure ulcer wounds. Resident #80 was admitted to the facility on [DATE], with a Pressure Ulcer/Injury to the sacrum. No treatments were ordered at that time. Treatments were administered 8 days after admission. The Pressure Ulcer/Injury deteriorated to a Stage 3 and on 2/22/2025, Resident #80 was transferred to the hospital for an infected wound. Resident #70 was admitted to the facility from the hospital on 7/14/2025 and hospital records documented his skin was intact. Nine (9) days after admission to the facility, a skin sweep identified a Stage 3 Pressure Ulcer/Injury on Resident #70's Right Buttock. The facility's failure resulted in Immediate Jeopardy (IJ) for Resident #80 and #70. The facility failed to ensure wound treatments were provided daily as ordered for Resident #8. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident. The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-686 on 8/7/2025 at 5:27 PM, in the Sunroom. The facility was cited Immediate Jeopardy at F-686. The facility was cited Immediate Jeopardy F-686 at a scope and severity of J which is Substandard Quality of Care. The Immediate Jeopardy began on 2/6/2025 through 8/11/2025, the IJ was removed on 8/12/2025. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on 8/11/2025 at 11:25 AM, and the Removal Plan was validated onsite by the surveyors on 8/11/2025 and 8/12/2025 through policy review, medical record review, review of education records, and staff interviews. The facility's non-compliance at F-686 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Charting and Documentation, dated July 2017, revealed .The following information is to be documented in the resident medical record .Medications administered .Treatments or services performed .the date and time the procedure/treatment was provided . Review of the facility policy titled, Prevention of Pressure Injuries, dated April 2020, revealed .Risk Assessment.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 (or soon after) admission with each risk assessment.Inspect the skin on a daily basis. 2. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Pneumonia, Malnutrition, Depression, Stage 5 Chronic Kidney Disease and Pressure Ulcer Stage 3. Review of the admission care plan for Resident #80 dated 2/6/2025, revealed .SKIN INTEGRITY .PROBLEM Wound care (see tx [treatment] orders) . Review of the INITIAL SKIN INJURY DOCUMENTATION for Resident #80 dated 2/6/2025, revealed .on admission.Sacrum.Length 10 CM [centimeter] Width.9 CM.Depth 0.1 CM. Review of the Wound Assessment for Resident #80 revealed, .Date of Assessment 02/8/2025.Present on admission. Sacrum .Pressure .Stage 2 .Odor.No.Length.10.50 [cm].Width.9.00 [cm].Depth.0.1 [cm]. Review of the Inpatient Physicians [Named Group Practice] form dated 2/8/2025, revealed .sacral P.U. [pressure ulcer also known as pressure wound] stage 3 / 4. Review of the 5 day Minimum Data Set (MDS) assessment dated [DATE], revealed a Bried Interview for Mental Status (BIMS) score of 15 which indicated Resident #80 was cognitively intact. Resident #80 was dependent on staff for all Activities of Daily Living (ADLs), always incontinent of bowel and bladder, and had a stage 2 pressure ulcer on admission. Review of the Physician's Orders for Resident #80 dated 2/12/2025, revealed .Begin Date 02/12/2025 .hydrocolloid [dressing to promote healing of wounds] 3 Times Weekly .SACRUM .Clean area with Normal Saline. Apply Hydrocolloid for autolytic debridement . Review of the February Treatment Administration Record (TAR) for Resident #80 revealed wound care to the sacrum was not ordered until 2/12/2025.hydrocolloid.Three Times weekly Starting 02/12/2025 . Review of the February TAR revealed no documentation wound care treatments were performed on the Resident's sacrum would until 2/14/2025, when the sacrum wound had declined to a Stage 3. Review of the Wound Assessment for Resident #80 dated 2/17/2025, revealed .Odor.No.Length.11.50 |

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the Resident [NAME] of Rights, medical record review, observation, and interview, the facility failed to provide an environment free of accident hazards when chemical aerosol room freshener and sharps were observed in 2 of 39 (Resident #56 and #57) resident rooms. There were 18 residents with wandering behaviors in the facility. The findings include: 1. Review of the .RESIDENT BILL OF RIGHTS, revealed This document lists your rights as a resident of the Facility .The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health of safety of the resident or other residents .Safe environment. The resident has a right to a safe, clean, comfortable .environment . 2. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Fracture of Lower End of Right Humerus, Diabetes, Acute Kidney Failure, and Adult Failure to Thrive. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11 which indicated Resident #56 was moderately cognitively impaired. Observations in Resident #56's room on 8/4/2025 at 10:21 AM and 1:10 PM, revealed (Brand Name) can of aerosol air freshener sitting in a plastic caddy on top of Resident #56's bedside table. During an interview on 8/4/2025 at 1:12 PM, the Assistant Director of Nursing (ADON) confirmed the can of aerosol air freshener should not be in the building. 3. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Diabetes, Hypertension, Depression, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 which indicated Resident #57 was cognitively intact. Observations in Resident #57's room on 8/4/2025 at 10:51 AM and 12:05 PM revealed a pair of scissors on Resident #57's bedside table. During an observation and interview in Resident #57's room on 8/4/2025 at 1:05 PM, Licensed Practical Nurse (LPN) D confirmed the Resident had scissors at the bedside, and they should not be there. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation, and interview, the facility failed to provide care and services to maintain an indwelling urinary catheter when nursing staff failed to obtain a physician's order and provide care and services for an indwelling urinary catheter for 2 of 2 (Resident #1 and #5) sampled residents for indwelling urinary catheters. The findings include: 1. Review of the facility policy titled, Medication and Treatment Orders, dated 7/2016, revealed .Orders for medications and treatments will be consistent with principles of safe and effective order writing.Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state. Review of the facility policy titled, Catheter Care, Urinary dated 8/2022, revealed .The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.Nursing and the interdisciplinary team should assess and document the ongoing need for a catheter that is in place. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with a readmit of 6/20/2025, with diagnoses including Benign Prostatic Hyperplasia, Obstructive Reflux Uropathy, and Cauda Equina Syndrome. Review of the Physician's Orders dated 2/15/2025, revealed .Cleanse catheter site with water and soap, rinse then pat dry QS [every shift]. Review of the Physician Orders dated 4/15/2025, revealed, Change 16FR [French] Indwelling Foley catheter once every month. Review of the Treatment Administration Record (TAR) for May 2025, revealed there was no documentation that indwelling catheter site care had been performed on 5/3/2025, 5/4/2025, 5/8/2025, 5/17/2025, 5/18/2025, 5/21/2025, 5/222025, and 5/31/2025 for Resident #1. The facility failed to provide documentation that the indwelling urinary catheter was changed during the month of May 2025. Review of the TAR for June 2025, revealed there was no documentation that indwelling catheter site care had been performed on 6/1/2025, 6/5/2025, 6/9/2025, 6/13/2025, 6/14/2025, 6/15/2025, 6/16/2025, 6/17/2025, 6/18/2025, 6/19/2025, 6/20/2025, 6/23/2025, 6/24/2025, and 6/27/2025 for Resident #1. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 15, which indicated Resident #1 cognitively intact, and had an indwelling urinary catheter. Review of the TAR for July 2025, revealed there was no documentation that indwelling catheter site care had been performed on 7/12/2025, 7/13/2025, 7/16/2025, 7/17/2025, 7/26/2025, 7/27/2025, 7/30/2025, and 7/31/2025 for Resident #1. During an interview on 8/6/2025 at 8:54 AM, the Lead of Quality Services confirmed that the facility was unable to provide clinical documentation for the May 2025 indwelling foley catheter change. During an interview on 8/6/2025 at 3:40 PM, the Director of Nursing (DON) confirmed that Physician's Orders should be followed and there should be no blanks on the Resident's Medication Administration Record (MAR) or TARS. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Fracture of Upper End of Left Tibia, Fracture of Shaft of Left Fibula, Lupus, Hypertension and Hyperlipidemia. Review of the care plan dated 6/23/2025, revealed .[Resident #5] has a [an] Indwelling Catheter. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated that Resident #5 was cognitively intact and had an indwelling catheter. Review of the Physician's Orders dated 6/2025 and 7/2025, revealed there were no orders for an indwelling catheter, catheter monitoring, or catheter care. Review of the Medication Administration Record (MAR) and TAR dated 6/2025 and 7/2025, revealed there was no documentation for indwelling catheter monitoring or catheter care. Observation in Resident #5's room on 8/4/2025 at 10:52 AM, revealed Resident #5 had an indwelling catheter. Review of the Physician's Orders dated 8/4/2025, revealed . Monitor Catheter urinary drainage bag and document the following every shift: Color, consistency, odor, hematuria, bladder distention, burning, sensation.Observe for s/s [signs and symptoms] of infxn. [infection] & complic. [complications] r/t [related to] use of FC [foley catheter].every shift FOR EARLY DETECTION OF POSSIBLE INFECTION FOR USE OF INDWELLING CATHETER.Secure indwelling catheter tubing using anchoring device/leg strap to prevent movement and urethral traction. Check placement Q [every] shift. Indwelling urinary (Named) catheter is in privacy bag, check for placement Q shift.Record Intake & Output . every shift for cath [catheter] care for 30 Days.Irrigate Indwelling catheter with 60 ml [milliliters] of Normal Saline PRN [as needed].Cleanse Indwelling catheter site with water and soap, rinse then pat dry .every shift. Change catheter drainage bag PRN.Change Indwelling Catheter Fr.(16) [catheter size] PRN. Review of the Physician's Orders dated 8/5/2025, revealed, .Indwelling Foley Catheter Fr 16/10cc [cubic centimeter].Check placement and patency Q daily. During an interview on 8/6/2025 at 10:33 AM, Licensed Practical Nurse |

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|---|---|---|---|
| | 445411 | A. Building<br>B. Wing | 08/12/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Applingwood Post Acute | 1536 Appling Care Lane<br>Cordova, TN 38018 |

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|---|---|
| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on education record review, medical record review, and interview, the facility failed to ensure that 4 of 7 (Licensed Practical Nurse (LPN) B, LPN F, LPN G, and LPN H) licensed nurses had the competencies and skill sets necessary to care for 1 of 1 sampled Residents (Resident #76) with a Laryngeal ([NAME])Tube. Based on education record review, medical record review, and interview, the facility failed to ensure that 4 of 7 (Licensed Practical Nurse (LPN) B, LPN F, LPN G, and LPN H) licensed nurses had the competencies and skill sets necessary to care for 1 of 1 sampled Residents (Resident #76) with a Laryngeal ([NAME])Tube. The findings include: 1. Review of the undated [NAME] Tube Education Record, revealed By signing this record of education, you acknowledge receiving educational training and a copy of the new process . Review of the education record revealed LPN B, LPN F, LPN G and LPN H did not receive the education and new process for the [NAME] tube. 2. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Surgical Aftercare Following Surgery on the Respiratory System, Malignant Neoplasm [cancer] of the Supraglottis [upper part of the larynx above the vocal cords], Malignant Neoplasm of the Lymph Nodes of the Head, Neck and Face, Diabetes, Dementia, and Anxiety. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was not able to be assessed and Resident #76 was severely cognitively impaired. Review of the Medication Record Administration (MAR) and Treatment Administration Record (TAR) dated 7/31/2025 and 8/2025 revealed LPN B, LPN F, LPN G, and LPN H provided care to Resident #76. Review of the Physician's Orders dated 8/1/2025, revealed .[NAME] [Laryngeal] TUBE- Change the HME [Heat Moisture exchangers] in daytime using the daytime HME and change to nighttime HME at bedtime. every morning and at bedtime for breathing through stoma [surgically created opening]. [NAME] TUBE- Change the HME daily at bedtime .[NAME] TUBE- Clean and disinfect [NAME] tube as needed if dirty and/or when mucus collects in [NAME] Tube . Review of the Nurses Notes dated 8/3/2025, revealed .trach [tracheostomy] cap popped out several times - changed this am and repositioned - stoma area tender with redness- remains weak and lethargic but responsive .requires total care . Review of the Physician's Orders dated 8/3/2025, revealed .[NAME] TUBE- Monitor the stoma site for signs of infection, lesions/ulcers, and drainage daily at bedtime, [NAME] TUBE- Clean and disinfect the [NAME] Tube daily at bedtime . Review of the progress notes dated 8/4/2025, revealed .[NAME] tube was cleaned .He [Resident #76] has frequently coughed up greenish- yellow phlegm causing the cap to come off. Frequent monitoring is required, and care is provided as needed . Review of the care plan dated 8/4/2025, revealed .Resident has laryngeal tube and is at risk for alteration in respiratory function related to diagnosis of laryngectomy .[NAME] ostomy care daily/PRN .Observe for signs and symptoms of obstructed airway or need for suctioning such as audible crackles, dyspnea [shortness of breath] .intervene promptly .Suction as needed/ Q2H [every 2 hours] . During an interview on 8/6/2025 at 3:27 PM, the Assistant Director of Nursing (ADON) was asked how she knows that staff are competent in caring for Resident #76 if they have not had education about the Laryngeal tube prior to their shift. The ADON stated, I don't. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored when medications were found unsecured and unattended in 2 of 39 (Residents #41 and #56) occupied resident rooms. The findings include: 1. Review of the facility policy titled, Medication Labeling and Storage, dated 2/2023, revealed .The facility stores all medications and biologicals in locked compartments. 2. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Dementia, Glaucoma, Memory Deficit, and Diabetes. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 6, which indicated Resident #41 was severely cognitively impaired. Observations in Resident #41's room on 8/4/2025 at 10:18 AM, 10:53 AM, and 1:02 PM, revealed (Brand Name) moisture barrier cream on Resident #41's bedside table. During an observation and interview in Resident #41's room on 8/4/2025 at 2:57 PM, Licensed Practical Nurse (LPN) A was shown the (Brand Name) moisture barrier cream on Resident #41's bedside table and confirmed that medication should not be left at bedside unsecured and unattended. 3. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Fracture Right Humerus, Diabetes, and Adult Failure to Thrive. Review of the annual MDS dated [DATE] revealed a BIMS score of 11 which indicated Resident #56 was moderately cognitively impaired. Observations in Resident #56's room on 8/4/2025 at 10:21 AM and 1:10 PM, revealed a (Brand Name) Antifungal Medication and (Brand Name) Antibiotic Ointment at bedside. During an observation and interview in Resident #56's room on 8/4/2025 at 1:12 PM, the Assistant Director of Nursing (ADON) confirmed medications should not be left in residents' rooms unattended and should be stored on the locked medication cart. During an interview on 8/5/2025 at 2:57 PM, the Director of Nursing (DON) confirmed medications should not be left unsecured and unattended at the resident's bedside and should be stored in a locked medication cart. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when Enhanced Barrier Precautions (EBP) were not followed for 2 of 2 (Resident #15 and #76) sampled residents. The findings include: 1. Review of the facility policy titled, Isolation-Categories of Transmission -Based Precautions, dated September 2022, revealed .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are indicated for residents with.Chronic wounds and/or indwelling medical devices. 2. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Dysphagia and Hemiparesis. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 was cognitively impaired. Review of the Physician's Order dated 2/15/2025, revealed .Enhanced Barrier Precautions during high contact time secondary to: PEG [Percutaneous Endoscopic Gastrostomy-tube in the stomach used for nutrition and medication] every shift related to HEMIPLEGIA AND HEMIPARESIS FOLLOWING CEREBRAL INFARCTION. Observation in Resident #15's room on 8/5/2025 at 5:01 PM, revealed Registered Nuse (RN) A administered medications through the PEG tube while wearing gloves but did not wear a gown which resulted in RN A not wearing appropriate personal protective equipment (PPE) according to the facility policy. During an interview on 8/6/2025 at 3:40 PM, the Director of Nursing (DON) confirmed that PPE should be worn when administering meds through a PEG tube. 3. Review of the medical record revealed Resident #76 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Surgical Aftercare Following Surgery on the Respiratory System, Malignant Neoplasm [cancer] of the Supraglottis [upper part of the larynx above the vocal cords], and Malignant Neoplasm of the Lymph Nodes of the Head, Neck and Face. Review of the discharge MDS assessment dated [DATE], revealed a BIMS score was not able to be assessed and Resident #76 was severely cognitively impaired. Review of the Physician's Order dated 8/4/2025, revealed . Enhanced Barrier Precautions during high contact time secondary to: (indwelling device), LARYOSTOMY suctioning for airway clearance as needed . Observation in Resident #76's room on 8/6/2025 at 8:17 AM, revealed Licensed Practical Nurse (LPN) I went in the room and did not don PPE. Resident #76's Laryngeal tube was out of his stoma, and the Resident was coughing yellow thick sputum through the Laryngeal stoma. LPN I went to the hall and called for help, went back in the room and did not don PPE. The Infection Preventionist came in the room and did not don PPE and assisted in placing the tube back in the stoma. Neither LPN I nor the Infection Preventionist performed hand hygiene prior to donning gloves and neither nurse wore proper PPE on for EBP during this invasive procedure. |

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| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and interview, the facility failed to provide a clean and sanitary environment for 1 of 39 (Resident #71) occupied resident rooms when walls were observed with brown dried dripping stains, a brown dried substance was observed on the head board of the bed, the floor, the wall behind the bed, the corner, on the wall near the window, and on the base of the enteral feeding pole. The findings include: 1. Review of the facility policy titled, Housekeeping - Routine Cleaning and Disinfection, dated 1/10/2025, revealed .Cleaning refers to the removal of visible soils from objects and surfaces.consistent surface cleaning will be conducted with a detailed focus on.Enteral pump poles.surfaces with infrequent hand contact. walls.should be cleaned on a regular basis. 2. Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Dysphagia, Aphasia, Chronic Obstructive Pulmonary Disease, and Diabetes. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 2, which indicated Resident #71 was severely cognitively impaired, and used a percutaneous endoscopic gastrostomy (PEG) tube. Observation in Resident #71's room on 8/4/2025 at 10:15 AM and 11:30 AM, revealed a dried dark and light beige colored dripping substance on the wall underneath the television, the wall near the heating and air conditioner unit, the wall behind the bed, in the corner of the room on the long wall behind the bed, on the headboard of the bed, and on the base and the wheels of the enteral feeding pole. During an observation and interview in Resident #71's room on 8/5/2025 at 11:42 AM, the Director of Nursing (DON) was shown the dried dark brown and beige substance on the walls, in the corner of the room behind the bed, on the headboard, and on the base and wheels of the enteral feeding pole and asked if those areas should have dried dark brown and beige substances on them. The DON confirmed the areas should be clean and not have dried substances on them. The DON was asked what the dried brown and beige substance on the walls, in the corner, on the headboard and on the enteral feeding pump were. The DON confirmed she was not sure, but it should not be there. |