STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445421	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Sparta	508 Mose Drive Sparta, TN 38583

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Review of the medical record revealed Resident #69 was admitted to the facility on [DATE] with diagnoses including Dementia, Atrial Fibrillation, and Heart Failure. Review of the comprehensive care plan for Resident #69 dated 2/4/2025, revealed .discharge plan .wishes to return home . Review of a Progress Note for Resident #69 dated 4/3/2025, revealed .Resident discharging home at this time in the care of her daughter. Discussed discharge instructions with resident and daughter. No questions or concerns voiced . Review of a discharge MDS assessment dated [DATE], revealed Resident #69 had a planned discharge to an acute care hospital. During an interview on 5/13/2025 at 7:52 AM, the DON confirmed Resident #69 was discharged home and the discharge MDS assessment dated [DATE] was inaccurate. Based on Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual review, medical record review, observations, and interviews, the facility failed to accurately complete an MDS assessment for 2 residents (Resident #21 and Resident #69) of 19 residents reviewed for MDS assessments. The findings include: Review of the MDS 3.0 RAI Manual dated 10/2024, revealed .discharge assessment .must be completed when the resident is discharged from the facility .SECTION A .discharge status .this item documents the location to which the resident is being discharged at the time of discharge .steps for assessment .review the medical record including the discharge plan and discharge orders for documentation of discharge location . coding instructions .Code Home/Community: if the resident was discharged to a private home .SECTION P . RESTRAINTS AND ALARMS .intent of this section is to record the frequency that the resident was restrained by any of the listed devices .was used at any time during the day or night, during the 7-day look-back period .Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories .Code 1, used less than daily: if the item met the definition and was used less than daily during the observation period . Trunk restraints include any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the resident cannot easily remove . (continued on next page)

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses including Congestive Heart Failure, Diabetes Mellitus, and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #21 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review of the quarterly MDS assessment revealed the resident had a trunk restraint used less than daily. Review of the comprehensive care plan for Resident #21 revised 3/17/2025, revealed the resident's plan of care did not include any limb restraints. During an observation and interview on 5/12/2025 at 12:00 PM, revealed Resident #21 lying in bed. Resident was able to move his lower extremities and there was no trunk restraint observed. The resident stated he had not used a trunk restraint at the facility. During an observation on 5/13/2025 at 8:15 AM, revealed Resident #21 was lying in bed and there was no trunk restraint observed in use. During an interview on 5/14/2025 at 7:50 AM, the Director of Nursing (DON) confirmed Resident #21 did not have a trunk restraint and the MDS assessment dated [DATE] was inaccurate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility documentation review, and interviews, the facility failed to obtain a physician's order for the use of an orthotic device (immobilizer) to include skin monitoring under the orthotic device for 1 resident (Resident #43) of 3 residents reviewed for orthotic devices. The findings include: Review of the facility's policy titled, Splints and Braces-Lower Extremity, dated 9/20/2024, revealed .the facility will provide .splints and braces .in accordance with professional standards of practice . of the patients affected body part .as ordered by practitioner .collaborate with the practitioner to help determine each device application . Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Left Femur Fracture, Diabetes, and Muscle Weakness. Review of an admission Braden Scale Assessment for Resident #43 dated 2/17/2025, revealed .Immobilizer to LLE [left lower extremity] . Review of an Order Summary Report dated 2/17/2025 through 2/24/2025, revealed Resident #43 did not have a physician's order for the immoblizer. Review of a Skilled Nursing Note for Resident #43 dated 2/18/2025, revealed .Immobilizer worn on L [Left]-leg . Review of a Skilled Nursing Note for Resident #43 dated 2/19/2025, revealed .Immobilizer worn on L-leg . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 scored a 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. The resident had impairment of one side of the lower extremity. The resident was total dependent upon staff assistance with personal hygiene, lower body dressing, and transfers. Review of a Skilled Nursing Note for Resident #43 dated 2/20/2025, revealed .Immobilizer worn on L-leg . Review of a Skilled Nursing Note for Resident #43 dated 2/21/2025, revealed .Immobilizer worn on L-leg . Review of a Skilled Nursing Note for Resident #43 dated 2/22/2025, revealed .Immobilizer worn on L-leg . Review of a Skilled Nursing Note for Resident #43 dated 2/23/2025, revealed .Immobilizer worn on L-leg . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Skilled Nursing Note for Resident #43 dated 2/24/2025, revealed .Immobilizer worn on L-leg . During an interview on 5/13/2025 at 12:17 PM, Certified Nursing Assistant (CNA) B stated she was familiar with Resident #43. CNA B stated when the resident was first admitted to the facility an immobilizer was worn on the left leg. The CNA also stated the immobilizer was not used currently. During an interview on 5/13/2025 at 12:22 PM, CNA C stated she was familiar with Resident #43. CNA C stated Resident #43 used to wear an immobilizer to her left leg (unsure of exact dates) and the resident no longer used the immobilizer. During an interview on 5/13/2025 at 12:32 PM, the Wound Care Nurse stated she was familiar with Resident #43. The resident was admitted to the facility from the hospital after surgical repair of a fracured left femur and had an immobilizer in place to the left leg. During an interview on 5/13/2025 at 12:41 PM, the Rehabilitation Director (RD) stated she was familiar with Resident #43 and when the resident was admitted to the facility she had an immobilizer in place to the left leg. During an interview on 5/13/2025 at 12:55 PM, PTA D stated he was familiar with Resident #43 and when the resident was admitted to the facility she had an immobilizer in place to the left leg. During an interview on 5/13/2025 at 1:43 PM, Resident #43's daughter stated Resident #43 wore an immobilizer to the left leg when she was admitted to the facility. She also stated the immobilizer had been discontinued on 2/24/2025. During an interview on 5/13/2025 at 1:47 PM, the Director of Nursing (DON) stated Resident #43 was admitted to the facility with an immobilizer in place to the left leg. The DON confirmed the nursing staff failed to obtain a physician's order for Resident #43's use of the immobilizer. The DON stated the facility identified the deficient practice of failing to obtain a physician's order to continue the use of the immobilizer and had taken actions to address the non-compliance. The DON stated a Performance Improvement Plan (PIP) was initiated on 2/24/2025. The DON further stated a 100% audit had been completed for all residents with orthotic devices to ensure physician orders were in place for the orthotic device. The DON stated the alleged date of compliance was 3/5/2025. A plan of correction was developed from 2/24/2025- 3/5/2025 to address the deficient practice identified. The corrective actions were validated on-site by the surveyor on 5/12/2025- 5/14/2025 through interviews and review of facility documents. The facility's Plan of Correction for obtaining a physician's order for orthotic devices was presented to the survey team and documented the following corrective actions were implemented: Review of a Witness Interview/ Statement form dated 2/24/2025, revealed .staff completed a 100% audit of all residents to verify who had any devices .orders verified . Review of a Witness Interview/ Statement form dated 2/25/2025, revealed .100% current residents assessed for braces and splints .All residents had MD [medical doctor] orders for device being used . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/25/2025 through 2/27/2025, the 90 active employees received education to address orthotic devices. 1. Audits for any orthotic devices of sampled residents were completed by the DON on 2/24/2025-2/25/2025 and confirmed there were no issues observed with orthotic devices. 2. During an interview on 5/13/2025 at 1:47 PM, the DON confirmed the facility had not had concerns with residents' who admitted to the facility with an orthotic device having a physician's order since the facility identified the deficient practice on 2/24/2025. 3. Surveyor interviewed multiple staff members (in various departments) from 5/13/2025-5/14/2025 for knowledge of the in-services provided in the corrective action plan, and no knowledge deficits were identified. The deficient practice was cited as past noncompliance for F-684 and the facility is not required to submit a plan of correction.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure proper infection control practices related to hand hygiene were followed during meal service when 1 staff member failed to offer hand hygiene assistance to 2 residents (Resident #10 and Resident #50) of 14 residents observed during meal tray distribution on 1 of 6 hallways. The findings include: Review of the facility's policy titled, Hand Hygiene for Residents, Families, and Visitors, revised 6/13/2023, revealed .the facility should assist either physically or through reminders to residents to perform hand hygiene .before meals . Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Left-Sided Hemiplegia, Muscle Weakness, and Tremors. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident required partial or moderate assistance with personal hygiene. Review of the comprehensive care plan for Resident #10 revised 4/2/2025, revealed .self care deficit .assist with ADLs [activities of daily living] . Review of the medical record revealed Resident #50 was admitted to the facility on [DATE] with diagnoses including Abnormalities of Gait and Mobility, Polyosteoarthritis, and Unsteadiness on Feet. Review of a quarterly MDS assessment dated [DATE], revealed Resident #50 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident required supervision or touching assistance with personal hygiene. Review of the comprehensive care plan for Resident #50 revised 4/21/2025, revealed .limited physical mobility .assist with ADLs . During an observation on 5/12/2025 at 12:29 PM, in Resident #10's room, revealed Certified Nursing Assistant (CNA) A brought Resident #10's tray into the room and placed the meal tray in front of the resident. CNA A opened the resident's silverware and opened the plate warming dome from the plate of food. Resident #10 picked up his fork and began eating the meal. Continued observation revealed CNA A failed to offer Resident #10 hand hygiene assistance prior to the resident eating the lunch meal. During an interview on 5/12/2025 at 12:30 PM, Resident #10 stated the staff did not offer hand hygiene assistance prior to the lunch service. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/12/2025 at 12:31 PM, in Resident #50's room, revealed CNA A brought Resident #50's tray into the room and placed the meal tray in front of the resident. CNA A opened the resident's silverware and opened the plate warming dome from the plate of food. Resident #50 picked up her fork and began eating the meal. Continued observation revealed CNA A failed to offer Resident #50 hand hygiene assistance prior to the resident eating the lunch meal. During an interview on 5/12/2025 at 12:33 PM, Resident #50 stated the staff did not offer hand hygiene assistance prior to the lunch service. During an interview on 5/12/2025 at 12:34 PM, CNA A confirmed she failed to offer hand hygiene to Resident #10 and Resident #50 prior to serving the lunch meal. During an interview on 5/14/2025 at 7:54 AM, the Director of Nursing (DON) stated the staff were to offer hand hygiene assistance to all residents before meal service. The DON confirmed infection prevention and control practices were not maintained during the lunch meal service on 5/12/2025 when CNA A failed to offer Resident #10 and Resident #50 hand hygiene assistance prior to the lunch meal service.