Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Weakley County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Weakley County Nursing Home Road Dresden, TN 38225	

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835 Based on policy review, facility investigation review, police report review, documentation review, medical record review, and interview, the facility failed to protect the resident's right to be free from abuse from another resident for 1 of 4 (Resident #42) sampled residents reviewed for abuse. The facility's failure to protect the resident's right to be free from abuse resulted in actual HARM, when on 1/17/2024, Resident #42 sustained two lacerations to the forehead when Resident #166 hit Resident #42 in the head with a hard plastic drinking cup. The findings include: 1. Review of the facility undated policy titled ABUSE PREVENTION POLICY revealed, .Every precaution will be taken to prevent mistreatment, neglect and abuse of residents .Residents must not be subjected to abuse by anyone, including .other residents . Review of the facility undated policy titled RESIDENT ABUSE POLICY revealed, .Purpose: To investigate any suspected or alleged abuse to residents by anyone. Definition: Abuse is the willful infliction of injury .with resulting physical harm or pain .PROCEDURE: ALLEGATION OF ABUSE BY ANOTHER RESIDENT . Allegations of abuse will be thoroughly investigated and documented .Residents will be protected from possible further abuse during the investigation . 2. Review of a Psychiatric Hospital Admission Record revealed Resident #166 was admitted to a behavioral health facility on 12/6/2023, with the Reason for Admission being .Patient lives at home with his spouse .hx [history] of Vascular Dementia .Wife reports on 11/28 [2023] .busted the front door, sheriff was called . has been throwing bricks at the wife and the windshield . Review of the medical record revealed Resident #166 was admitted to the nursing home facility on 1/4/2024, with a diagnosis including Dementia with Agitation and Behaviors. Resident #166 was documented to have behaviors from admission on 1/4/2024 until discharge on [DATE]. The behaviors included wandering the halls, going into other resident's rooms, rummaging through other's belongings and the Personal Protective Equipment (PPE) carts on the hall, yelling, cursing, disrobing, and grabbing staff and experienced sexually inappropriate behaviors toward staff. Resident #166's prescriptions of antipsychotic, antidepressants, and anxiety medications and redirection were ineffective in controlling the Resident's behaviors. (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 0600 Level of Harm - Actual harm Residents Affected - Few	Physician Orders revealed, .UA with C&S [urinalysis culture and sensitivity test] 1/4/2024 .Document adverse behaviors [Target behaviors .] .Haloperidol 1 mg [milligram] two times a day for agitation/anxiety .Haloperidol 2 mg at bedtime for agitation/anxiety .Lorazepam 1 mg every 4 hours as needed for anxiety . Review of a Nursing Progress Note dated 1/4/2024 at 12:47 PM revealed at 8:03 PM, Resident #166 struck Licensed Practical Nurse (LPN) B as she was walking out the door of his room. Review of a Nursing Progress Note dated 1/6/2024 at 1:26 PM, revealed Resident #166 was observed walking in the hallway while naked, and at 6:38 PM, Resident #166 was found in another resident's room. When Certified Nursing Assistant (CNA) E attempted to redirect Resident #166 back to bed, Resident #166 grabbed CNA E's arm and told her he was going to break it. The Resident then grabbed CNA E by the throat and told her he was going to kill her. Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #166 scored a 2 on the Brief Interview for Mental Status (BIMS), which indicated the Resident had severe cognitive impairment. Resident #166 was dependent on staff for all care except for feeding self. Review of a Nursing Progress Note dated 1/14/2024 at 5:13 PM, revealed Resident #166 wandered into the Activity Room and had both hands on a resident's head before being redirected by LPN B. Review of a Nursing Progress Note for Resident #166 dated 1/17/2024, revealed .called to the room of [named Resident #42] . This resident [Resident #166] went into his [Resident #42] room and picked up phone . [Resident #42] put phone back. Then resident [Resident #166] went over to . [Resident #42] picked up water glass and stuck [struck] him [Resident #42] in the head. Resident [#42] has 2 [two] cut about 1/4 inch at left eye brow. Resident [#166] was redirected to his room . Resident #166 was discharged from the nursing facility to a Psychiatric Hospital on 1/17/2024 after the incident with Resident #42. Review of Resident #166's Care Plan dated 1/18/2024, (after Resident #166 was discharged from the facility) revealed .The resident has a behavior problems: entering other residents room, rummaging, spitting, agitation, anxious/restlessness, wandering, grabbing others, hitting others, kicking others, pushing others, physically aggressive towards others, exit seeking, expressing anger at others, screaming at others, threatening others, disrobing in public, public sexual acts, throwing/smearing food, delusions, hallucinations, panic, withdrawn .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes .wander guard to leg as ordered to alert staff of any attempts to elope .Administer Depakote, Haloperidol, Seroquel, Zoloft as ordered. Monitor for side effects/effectiveness. Notify MD as needed .The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia, BIMS, inattention, disorganized thinking, wandering, and behaviors . The resident has delirium or an acute confusional episode r/t BIMS, inattention, disorganized thinking .Provide medications to alleviate agitation as ordered by MD. Monitor/document side effects and effectiveness . There was no documentation of a Care Plan for Resident #166's behaviors prior to the Resident's discharge from the facility. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Polyneuropathy, Diabetes, Peripheral Vascular, Chronic Kidney Disease, Heart Disease, Non-Pressure Chronic Ulcer of Right Foot, and Hypertension. Review of the Annual MDS dated [DATE], revealed Resident #42 scored a 15 on the BIMS, which indicated the Resident had no cognitive impairment. Resident #42 was independent and required minimal assist. Review of the weekly skin assessment for Resident #42 dated 1/17/2024, revealed Resident #42 with two lacerations on the left side of the forehead, both measuring 0.4 centimeters (cm) long. Review of facility records and the facility investigation revealed on 1/17/2024, Resident #166 wandered into Resident #42's room. Resident #166 picked up a hard plastic drinking cup and hit Resident #42 in the forehead causing a laceration to the Resident's forehead. Review of the Witness Statement by LPN B on 1/17/2024 at 3:45 PM, revealed Resident #42 had been involved in an altercation with Resident #166, .called to Room [number of the room] . [Resident #166] . wandered into [Resident #42's room] . and struck Resident [Resident #42] . in the head with a water glass. Resident has 2 [two] 1/4 [one quarter] inch cuts at left eyebrow . Review of the Witness Statement by Social Services on 1/17/2024 at 4:25 PM, revealed, .resident [Resident #42] .stated resident .[Resident #166] walked into his room and picked up the phone. Resident [Resident #166] . then knocked everything off the bedside table and spilled the water all over the floor. Resident [Resident #166] . then hit [Resident #42] .with the glass in his hand on his left temple and cheek area. A nurse assisted [Resident #42] . with his cut [laceration] . Review of the quarterly MDS dated [DATE], revealed Resident #42 scored a 15 on the BIMS, which indicated the Resident had no cognitive impairment. Resident #42 was independent and required minimal assist. 4. During an interview on 6/28/2024 at 8:30 AM, CNA E was asked to describe the incident of Resident #166 grabbing her arm and throat and threatening her. CNA E stated she tried to redirect Resident #166 and pulled up his briefs, but the Resident was very agitated and kept pulling away from her. CNA E stated she was walking Resident #166 down the hallway and the Resident was very agitated, and .grabbed my arm as hard as he could and said he was going to break if off . CNA E stated Resident #166 then grabbed her (CNA E) by the throat and said he, .was going to [F word expletive] kill me . CNA E stated at this point she [CNA E] was very upset and stated, . I just dropped everything and walked out . CNA E stated she told the charge nurse what had happened and that she (CNA E) was told to write a statement and chart the behaviors. CNA E stated, .I wrote the statement .I think I may have just left it on the nurse station, but I don't believe I charted the behaviors .I can't remember .it was all such a blur after that . CNA E stated no one interviewed her or talked about the incident. During an interview on 6/28/2024 at 10:56 AM, the Director of Nursing (DON) stated, .he [Resident #166] was a handful .wandered . very agitated .hard to redirect . The DON was asked what interventions were put into place. The DON stated, . we referred him [Resident #166] to psych services .tried redirection .notified the doctor .PRN [as needed] Ativan [a medication for anxiety) for his agitation . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/28/24 at 10:56 AM, the DON was asked if she felt like adequate interventions were put into place to keep staff and resident's safe. The DON stated, .In hindsight, probably not . trying to think of him [Resident #166] particularly with him having issues coming in .we didn't do one on one . outside of putting stop signs on everyone's doors to keep him [Resident #166] from going in there .I don't know what else we could have done .other than he's [Resident #166] leaving and not coming back kind of thing again that's hindsight. That's what we know now .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on facility policy, medical record review, observation, and interview, the facility failed to ensure residents were free of physical restraints for 1 of 1 (Resident #9) sampled residents reviewed for restraints. The findings include: 1. Review of the facility policy titled, Restraint Free Environment dated 3/28/2019, revealed .A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body .physical restraints may be used on emergency care situations for brief periods .Falls do not constitute self-injuries, behavior or a medical symptom that warrants the use of a physical restraint .A physician's order alone is not sufficient to warrant the use of a physical restraint .the length of time the restraints anticipated to be used .time and frequency that the restraint will be released .The type of direct monitoring and supervision that will be provided during the use of the restraint . 2. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Dementia, and Non-Traumatic Brain Dysfunction. Review of the care plan dated 4/10/2023, revealed .Resident had actual fall. Date Initiated: 05/05/2023 Revision on: 02/26/2024 .Intervention .Implement self-release seat belt. Date Initiated: 06/12/2023 .Follow facility fall protocol . Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #9 had a Basic Interview for Mental Status (BIMS) score of 3, which indicated Resident #9 was severely cognitively impaired. The resident required maximum assistance for all mobility, had no falls since the prior assessment, used a floor mat alarm, Wander alarm and other alarm daily. Review of the Order Summary Report dated 6/25/2024, revealed there was no physician's order for the self-release seat belt. Observation and interview in the front lobby on 6/24/2024 at 9:30 AM, revealed Resident #9 was sitting in the wheelchair with a self-release seat belt around her waist. Resident was asked if she could unlatch the seat belt. She looked at it and pulled on it and was not able to release the belt. Observation and interview in the resident's room on 6/24/2024 at 12:25 PM, revealed Resident #9 was unable to release the seat belt when asked by the surveyor. Observation and interview in the front lobby on 6/25/2024 at 8:38 AM, revealed Resident #9 was asked if she could release her seat belt. The resident looked at the seat belt and stated she didn't know how to do that and looked at it. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation in the front lobby on 6/25/2024 at 3:37 PM, revealed Resident #9 had the seat belt in place. During an interview on 6/25/2024 at 4:10 PM, the Director of Nursing (DON) was asked if the resident had a restraint. The DON stated, She can release the belt herself . The DON and the surveyor went to the resident in the hall and the DON asked Resident #9 if she could release the seat belt. The DON asked several times and in different ways for the resident to release the seat belt. Resident #9 was not able to release the seat belt without being told to press the button while the DON tapped the red button. The DON was asked if that was a restraint. The DON stated, Well, now it is since she can't undo it . The DON was asked if there should be an order for a restraint. The DON states, Yes, but this is a no restraint facility so we will have to figure something else out. The DON confirmed something should have been on the Treatment Administration Record to ensure the resident was able to release the seat belt.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49311 Based on policy review, medical record review, facility investigation, named Sheriff's Department Incident Report, and interview, the facility failed to thoroughly investigate an alleged incident of Employee to Resident abuse for 1 of 4 sampled residents (Resident #216) reviewed for abuse. The findings include: 1. Review of the undated facility policy titled Nursing Home's Resident Abuse Policy, revealed .Procedure: Allegation of abuse by an employee .will be thoroughly investigated and documented .Any staff member who witness a suspicious situation .is to immediately notify the supervisor on duty .The Charge nurse will examine the alleged victim immediately and complete an incident report with a summary of her interview and notify the Director of Nursing and the Administrator . Review of the facility policy titled Investigation Reporting/Response dated 5/2024, revealed .The facility will have written procedures that include .Reporting of all alleged violations to the Administrator, state agency, adult protective services and all other required agencies (e.g., law enforcement when applicable) .Taking all necessary actions as a result of the investigation, which may include, but not limited to, the following . Analyzing the occurrence(s) to determine why abuse .occurred and what changes are needed to prevent further occurrences .Defining how care provisions will be changed and/or improved to protect residents . 2. Review of the medical record revealed Resident #216 was admitted to the facility on [DATE], with diagnoses including Respiratory Failure, Depression and Dementia. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #216 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated she was moderately cognitively impaired without behaviors. Review of the Employee to Resident Allegation of Abuse investigation provided by the facility revealed there was no Incident Report or summary provided. Review of the witness statements all dated 10/23/2023, and untimed revealed the incident had happened on 10/22/2023. The incident was not reported to the Abuse Coordinator (Administrator) until the following day. Review of the named Sheriff's Department Incident Report dated 10/26/2023, revealed .At this point I have decided there is not sufficient evidence to warrant further investigation or prosecution. The alleged victim is not in danger as she is no longer exposed to her accused abuser .I cannot determine if the incident did or did not occur but I am declining to further continue an investigation unless new compelling evidence arises . Investigation summary and documentation that a report had been made to Adult Protective Services was unable to be provided by the Administrator. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/2024 at 3:36 PM, the Administrator was asked if she had done a thorough investigation. The Administrator stated that she had given me everything that she had for the investigation. The Administrator was asked if there was an incident report done by the nurse. The Administrator confirmed an incident report had not been completed. When asked where her investigation was, she stated it was in the IRS (Incident Reporting System). During an interview on 6/27/2024 at 3:45 PM, the Director of Nursing was asked if she felt this was a complete investigation. She stated, .I feel like a narrative would be helpful and a good idea going forward. The facility failed to conduct a thorough investigation for an allegation of Employee to Resident Abuse. The facility failed to immediately report the allegation of abuse to the Abuse coordinator. The incident was not investigated until the day after the allegation. An incident was not completed in accordance with the facility policy. And Adult Protective Services was not notified.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50780 Based on policy review, medical record review and interview, the facility failed to complete a baseline care plan within 48 hours for 2 of 10 (Resident #21 and 369) sampled residents reviewed for baseline care plans. The findings include: 1. The facility policy titled, Baseline Care Plan revised 12/5/2022, revealed, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .The baseline care plan will .be developed within 48 hours of a resident's admission .include the minimum healthcare information necessary to properly care for a resident including, but not limited to .Initial goals based on admission orders .Physician orders .Dietary orders .Therapy services .A supervising nurse shall verify within 48 hours that a baseline care plan has been developed . 2. Review of the medical record revealed Resident #21 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Chronic Atrial Fibrillation, Diabetes, Dialysis, and End Stage Renal Disease. Review of the Baseline care plan dated 11/11/2023, revealed the baseline care plan was initiated but not completed when it was left unsigned by the resident or family. During an interview with the Minimum Data Set (MDS) Coordinator on 6/26/2024 at 2:30 PM, revealed the MDS Coordinator confirmed Resident #21's base line care plan was not signed by the resident or family within 48 hours of initial admission or hospital return. 3. Review of the medical record revealed Resident #369 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Pneumonia, Congestive Heart Failure, Diabetes, Hypertension, and Benign Prostatic Hypertrophy. Review of the Baseline care plan dated 5/20/2024, revealed that the baseline care plan was initiated but not completed it was left unsigned by the resident or family. During an interview on 6/28/2024 at 12:00 PM, the MDS Coordinator confirmed that the baseline care plans should be signed by the resident or the family. The MDS Coordinator confirmed that Resident #369's baseline care plan was not signed by the resident or the family.

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50780

Based on review of the State licensure regulations, job description review, policy review, medical record review, review of facility investigations, observation, and interview, the facility failed to ensure the environment was free from accident hazards when dangerously elevated hot water temperatures were measured for 8 of 69 (Resident Rooms #13, #17, #18, #86, #89, #90, #91, #93) rooms, and when the facility failed to provide a safe environment and adequate supervision to prevent falls and injury for 7 of 7 (Resident #2, #11, #21, #28, #46, #52, and #54) sampled residents reviewed for accidents. On 6/24/2024 and 6/28/2024, dangerous elevated hot water temperatures ranging from 123 degrees Fahrenheit (F) to 130 degrees Fahrenheit (F) were observed in 8 of 69 (Resident Rooms #13, #17, #18, #86, #89, #90, #91, #93). Two Residents who were physically and/or cognitively impaired (Residents #43 and #52) resided in a room with elevated dangerous hot water temperatures and two residents were able to access the hot water in their rooms. Two cognitively intact (Residents #40 and #55) stated the water would get too hot. The facility's failure to prevent the dangerously elevated hot water temperatures placed all residents with the ability to access the hot water in Immediate Jeopardy. The facility's failure to implement effective fall interventions resulted in actual harm when Resident #11 fell and sustained a closed fracture (broken bone) of the left distal femur (large upper bone of the leg).

The failure of the facility to maintain safe hot water temperatures placed all residents with access to these rooms in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance has caused, or has potential to cause serious injury, harm, impairment, or death to a resident). The facility's census was 63.

The Administrator, Director of Nursing (DON) and the Maintenance Supervisor were notified of the Immediate Jeopardy (IJ) for F689 on 6/24/2024 at 3:23 PM, in the facility Conference Room.

An acceptable allegation of removal was received on 6/25/2024 at 12:38 PM. On 6/28/2024 beginning at 8:38 AM, while attempting to validate the allegation of removal, dangerously elevated hot water temperatures ranging from 122.5 degrees F to 123.6 degrees F were observed in resident rooms #13, #17 and #18.

The Administrator was notified of the Immediate Jeopardy (IJ) for the amended F689 on 6/28/2024 at 10:47 AM, in the facility Conference Room.

An extended survey was conducted 6/26/2024 through 6/28/2024.

The Immediate Jeopardy for F-689 began on 6/24/2024. The Immediate Jeopardy is ongoing.

The findings include:

1. Review of the State Licensure Regulations, CHAPTER 0720-18 STANDARDS FOR NURSING HOMES revised July 2022, revealed at 720-18-.08 17 (c), Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105 F and 115 F.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. Review of the undated ADMINISTRATOR JOB DESCRIPTION revealed .Position Purpose .Leads, guides, and directs the operations of the healthcare facility in accordance with local state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents .Plans, develops, implements, evaluates, and directs the overall operation of the facility as well as its programs and activities in accordance with current state and federal laws and regulations . Leads and coordinates .management team meetings to discuss priorities and develop solutions .Knows and understands general nursing practices and procedures .Code of Federal Regulations, Appendix PP State Operations Manual .collaborates with members of the interdisciplinary team .to resolve issues . Promotes . effective communication .Ensures the facility's plan of correction response to any regulatory, inspection survey is completed, adequate, implemented, and timely .Communicates directly with .medical staff, nursing staff .department heads, and members of the interdisciplinary team to coordinate care .Responds and resolves complaints and concerns . Protects residents from abuse .Follows established infection control policies . Review of the undated DIRECTOR OF NURSING JOB DESCRIPTION revealed .Position Purpose . Planning, organizing, developing, and directing the overall operations of the Nursing Service Department in accordance with local, state, and federal standards and regulation, established facility policies .to provide appropriate care and services to the residents .Communicates policies and procedures to nursing staff and monitors staff practices and implementations .Participates in daily or weekly management team meetings to discuss .resident change in status, complaints, or concerns .Ensures delivery of .quality care .Oversees resident incidents .daily .reports them promptly to the Administrator .for appropriate action .Monitors for allegations of potential abuse or neglect .and participates in the investigative process .Acts in an administrative capacity in the absence of the administrator . Review of the undated MAINTENANCE DIRECTOR JOB DESCRIPTION revealed, .Position Purpose . Directs .Maintenance Department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility and to assure the facility is maintained in a safe and comfortable manner .Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility which includes .plumbing .Develops and implements preventative maintenance tasks .instructions, and procedures for the preventative maintenance of the facility .Ensures the facilities compliance with the law and other regulatory terms such as safety . Performs and monitors required inspections of facility equipment .Maintains a safe and secure working environment free of .situations that could cause harm .to residents, families, visitors . 3. Review of the facility policy titled, .FALL PROGRAM GUIDELINES, dated 11/8/2019, revealed FALL RISK ASSESSMENT PURPOSE: IDENTIFY RESIDENTS AT RISK FOR FALLS AND APPLY MEASURES TO REDUCE THE OCCURRENCE OF ALL RELATED INCIDENTS .Complete a Fall Risk Assessment form on admission, quarterly and prn [as needed]. A resident who scores 7 or higher on the Fall Risk Assessment will be considered high risk for falls. If it is determined that a resident is high risk for falls perform the following: Review and assess on a quarterly basis or with significant changes- resident's fall history, environmental factors and mediation use which could contribute to the risk of falling .Perform personal assessment on resident to address factors which would increase fall risk with annual MDS [Minimum Data Set] assessments or any significant changes of status .Assess resident for need to use adaptive equipment that could decrease fall risk, such as, walker, quad cane, body alarm, low bed or other adaptive equipment as determined on an individual basis .Care plan risk factors and any interventions in place for each individual based on their specific needs .Fall Risk Assessment will include assessment of anticoagulant use with severely impaired cognitive residents . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Weakley County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Weakley County Nursing Home Road Dresden, TN 38225	

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, .POST FALL GUIDELINE, dated 11/8/2019, revealed PURPOSE: TO EVALUATE EACH INDIVIDUAL FALL AND DETERMINE NEW INTERVENTIONS FOR THE EVENT OF FUTURE FALLS .Complete Post Fall Investigation Form immediately after a fall for each resident when a fall occurs .The immediate intervention of Q 15 [every 15] minute checks will act as a care planned intervention until the Fall Committee meets and reviews the fall; At that time of the Fall meeting the immediate intervention will become void .The Fall Committee will collaborate and form a fall intervention based on the resident's individual needs and medical condition .The Fall Committee Leader will complete a Fall Investigation and develop a summary of the events surrounding each individual fall. 4. The surveyor's thermometer was calibrated (a procedure using ice water to ensure the thermometer is measuring correctly) before water temperature checks were obtained. The surveyor's hot water temperature checks in resident rooms on 6/24/2024 beginning at 10:11 AM, revealed the following: room [ROOM NUMBER] was 130 degrees F. room [ROOM NUMBER] was 122 degrees F. room [ROOM NUMBER] was 122 degrees F. room [ROOM NUMBER] was 130 degrees F. The Maintenance Director and the surveyors' hot water temperature checks using a calibrated thermometer in resident rooms on 6/24/2024 beginning at 12:11 PM, revealed the following: room [ROOM NUMBER] was 126 degrees F. room [ROOM NUMBER] was 125 degrees F. room [ROOM NUMBER] was 123 degrees F. room [ROOM NUMBER] was 123 degrees F. room [ROOM NUMBER] was 123 degrees F. The Maintenance Director and the surveyor's hot water temperature checks using a calibrated thermometer in resident rooms on 6/28/2024 beginning at 8:38 AM, revealed the following: room [ROOM NUMBER] was 123.6 degrees F. room [ROOM NUMBER] was 123.6 degrees F. room [ROOM NUMBER] was 122.5 degrees F. 5. Review of the current MDS assessments revealed Residents #43 and #52 were cognitively and/or physically impaired, and the residents had access to the hot water with the dangerously elevated hot water temperatures. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility provided a list of residents who wander. The list revealed Residents #43 and #52 were cognitively impaired and had been identified by the facility as Residents with wandering behaviors (random, repetitive, or aimless locomotion/movement throughout an area) and had the potential to be affected by dangerously hot water temperatures. 6. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Fracture of the Right Femur, Fracture of Shaft of Right Radius, and Dementia. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #17 scored a 6 on the Brief Interview for Mental Status (BIMS) which indicated the Resident was severely cognitively impaired. Observation and interview in Resident #17's bathroom with the Maintenance Director present on 6/28/2024 at 8:45 AM, revealed a hot water temperature of 122.5 degrees F in the hand sink. The Maintenance Director stated, It's out of range, too high. 7. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Dysphagia, Anxiety, Hypertension and Osteoarthritis. Review of the admission MDS dated [DATE], revealed Resident #40 scored a 14 on the BIMS, which indicated the resident was cognitively intact. Resident required moderate assistance with Activities of Daily Living (ADLs). Observation and interview in the Resident #40's room on 6/24/2024 at 9:38 AM, revealed the Resident was sitting up in a chair his room. The Resident reported that water was hot when washing hands in the bathroom. Resident #40 resided in a room which measured a dangerously hot water temperature of 123 degrees F. 8. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Diabetes. Review of the admission MDS dated [DATE], revealed Resident #41 scored a 15 on the BIMS, which indicated the Resident was cognitively intact. Observation and interview in Resident #41's bathroom with the Maintenance Director present on 6/28/2024 at 9:40 AM, revealed a hot water temperature of 123.6 degrees F in the hand sink. The Maintenance Director stated, It's too high . 9. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Major Depression, Asthma, and Urinary Tract Infection. Review of the Physician's Order dated 8/10/2023, revealed WANDER GUARD TO LEG AS ORDERED . Review of the quarterly MDS dated [DATE], revealed Resident #43 scored a 4 on the BIMS, which indicated the Resident was severely cognitively impaired. The Resident required moderate assistance from staff to perform ADLs. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observation and interview in the Resident #43's room on 6/24/2024 at 9:33 AM, revealed the Resident was resting in bed and was asked about the water temp in her bathroom. The Resident stated the water gets too hot and will scald you if you don't add cold water with the hot water. Resident #43 resided in a room which measured a dangerously hot water temperature of 123 degrees F. Observation and interview in the Resident #43's bathroom with the Maintenance Director present on 6/24/2024 at 12:09 PM, revealed a hot water temperature of 123 degrees F in the hand sink. The Maintenance Director stated, It's hot. It's over the limit today girls. We had trouble with that boiler [water heater], so I had to turn it up. 10. Review of the medical record revealed Resident #44 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Chronic Obstructive Pulmonary Disease, Depression, and Heart Failure. Review of the quarterly MDS dated [DATE], revealed Resident #44 scored a 15 on the BIMS, which indicated the Resident was cognitively intact. The Resident required supervision assistance of staff to perform ADLs. Observation and interview in Resident #44's bathroom on 6/24/2024 beginning at 12:15 PM with the Maintenance Director present revealed a hot water temperature of 125.8 degrees F. The Maintenance Director stated, This is my fault. I did not turn the boiler [water heater] back down. The Maintenance Director was asked when the boiler was turned up. The Maintenance Director stated, Last week sometime maybe Monday [6/17/2024] .We had a bird get in the pipe. The Maintenance Director was asked what the boiler was usually set on. The Maintenance Director stated, 120. The Maintenance Director was asked what the boiler temperature was turned up to. The Maintenance Director stated, 134. Observation of the North Hall utility room on 6/24/2024 at 12:19 PM with the Maintenance Director present revealed a water heater that was set at 135 degrees F. 11. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], with diagnoses including Coronary Artery Disease, Heart Failure, Cerebrovascular Vascular Accident, and Dementia. Review of the significant change MDS dated [DATE], revealed Resident #52 scored a 6 on the BIMS, which indicated he was severely cognitively impaired. Resident #52 resided in a room which measured a dangerously elevated hot water temperatures of 123 degrees F and had the ability to access the hot water. 12. Review of the medical record revealed Resident #55 was admitted to the facility on [DATE], with diagnoses including Hypertension, Chronic Kidney Disease, Chronic Diastolic Heart Failure, Asthma, Depression, and Coronary Artery Disease. . Review of the quarterly MDS dated [DATE], revealed Resident #55 scored a 14 on the BIMS, which indicated the Resident was cognitively intact. Resident #55 required maximum assistance of staff to perform ADLs and the use of wheelchair required for mobility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #55 resided in a room with a dangerous hot water temperature of 126 degrees F and the ability to reach the water. 13. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Congestive Heart Failure and Coronary Artery heart Disease. Review of the admission MDS dated [DATE], revealed Resident #59 scored a 5 on the BIMS, which indicated the Resident was severely cognitively impaired. Observation and interview in Resident #59's bathroom with the Maintenance Director present on 6/28/2024 at 8:45 AM, revealed a hot water temperature of 122.5 degrees F in the hand sink. The Maintenance Director stated, It's out of range, too high. During an interview on 6/24/224 at 12:20 PM, the Maintenance Director was asked how often water temperatures were checked. The Maintenance Director stated, Once a week . During an interview and observation of the North Hall Utility Room on 6/24/2024 at 12:49 PM, the Maintenance Director was asked, what was the difference in a water heater and a boiler. The Maintenance Director stated, They both do the same thing . The Maintenance Director confirmed the facility had a water heater, but he referred to it as a boiler. The Maintenance Director was asked what alerted him that there was a problem with the water temperature last week. The Maintenance Director stated, The water temps [on the North Hall] were off. They were 103-110 [degrees F.]. The Maintenance Director was asked if he had documented the water temps from the North Hall. The Maintenance Director stated, No, because I got them [water temps] back where they were supposed to be. The Maintenance Director was asked if the water temperatures were rechecked after the water heater had been turned up. The Maintenance Director stated, Yes. Thursday [6/20/2024] or Friday [6/21/2024]. The Maintenance Director was asked if these water temperature checks were documented. The Maintenance Director stated, No ma'am. The Maintenance Director was asked how the bird got in the water heater pipe. The Maintenance Director stated, It's a gas water heater. The Maintenance Director pointed to a pipe coming from the water heater and going to the wall, and stated, That is an exhaust pipe that lets fumes out. Observation outside the building revealed a white pipe sticking out from the side of the building with a mesh covering the end. The Maintenance Director confirmed the end of the pipe had been uncovered since the water heater was installed on 9/8/2021, and that he had placed the mesh on the end after 2 birds got in the pipe. The Maintenance Director stated, That is a vent to let the exhaust fumes out, the birds getting in stopped the fumes from getting out and the hot water heater shut off. The Maintenance Director confirmed he was the only one who checked water temperatures in the resident rooms. The Maintenance Director was asked should he have documented when the water temperatures were low. The Maintenance Director stated, No I had one that was right. I only have to have one from each hall. I don't have to document them all unless you all have changed your guidelines. The Maintenance Director was asked should he have documented that he had rechecked the water temps later in the week once he had increased the temperature of the water heater. The Maintenance Director stated, Last Friday [6/21/2024] I was good, and I needed to turn it back down .I didn't turn it back down. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 6/24/2024 at 1:22 PM, the Administrator was asked if she was aware there were some problems with the water temperatures last week. The Administrator stated, No ma'am. The Administrator was asked were you notified that there was a problem and the Maintenance Director had to turn up the temperature on the water heater. The Administrator stated, No, not that I recall. The Administrator was asked, have you been notified today that you have water temperatures greater than 120 degrees. The Administrator stated, No ma'am. During an interview on 6/24/2024 at 3:02 PM, the Administrator was asked who monitored water temperatures. The Administrator stated, That would be [named the Maintenance Director]. The Administrator was asked do you expect him to notify you if the water temperatures are out of range. The Administrator stated, Yes. The Administrator was asked what staff should do if they think the water is too hot. The Administrator stated, They should call [named the Maintenance Director] .he is always on call . The Administrator was asked were you aware of any problems with the water temperatures. The Administrator stated, No ma'am. The Administrator was asked has [the Maintenance Director] reported any problems with the water temperatures today. The Administrator stated, No ma'am. During an interview on 6/24/2024 at 3:10 PM, the Maintenance Director confirmed he checked water temperatures weekly. The Maintenance Director was asked, when did he notice the water temperature was low last week. The Maintenance Director stated, They [facility staff] called me and told me they didn't have no hot water. The Maintenance Director was asked who called him. The Maintenance Director stated, I'm not for sure, a CNA [Certified Nursing Assistant] or the hairdresser .I found the bird in there, so I boosted the temps up [on the hot water heater] to get it where it needed to be, because I needed to get my water temps. I told the guy who works with me, we aren't going to record these temps yet . The Maintenance Director was asked, when staff called you, did you put in a work order. The Maintenance Director stated No, I just started addressing the problem. The Maintenance Director was asked when you have a problem like the one last week [with the water temperatures] do you let the Administrator know. The Maintenance Director stated, I try to, but I don't tell her every little thing. During an interview on 6/28/2024 at 9:20 AM, the Administrator confirmed the Maintenance Director had notified her that there was a problem with the water being too hot but did not tell her the temperature of the water. During an interview on 6/28/2024 at 4:11 PM, the Administrator confirmed she had not notified the Medical Director of the Immediate Jeopardy and that the facility had not conducted an ad hoc [when necessary] QAPI [Quality Assurance Performance Improvement] meeting related to the water temperatures. 14. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], and a reentry date of 5/11/2024, with diagnoses including Left Femur Fracture, Alzheimer's Disease, Malnutrition, Glaucoma, Osteoporosis, Congestive Heart Failure, and Insomnia. Review of the Care Plan dated 7/5/2023, revealed .Fall r/t [related to] poor safety awareness . Offer toileting at bedtime and upon rising. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the quarterly MDS dated [DATE], revealed Resident #11 scored an 8 on the BIMS, which indicated severe cognitive impairment, and required moderate assistance with bed mobility and sit to stand, maximum assistance with toileting and toilet transfer, and was always continent of bowel and bladder, was not on a toileting program, and experienced two (2) or more falls with no injury since admission or prior assessment. Review of Resident #11's Un-witnessed [Fall Report], for Fall #1, dated 12/13/2023 at 5:31 AM, revealed . This nurse heard a sound come from resident's room, as this nurse entered the room nurse observed resident sitting in the floor .Resident states she had an accident and was trying to get cleaned up and fell . assisted to W/C [wheelchair] .Bed linen changed. Resident assisted back to bed .Oriented to Person . Incontinent .Ambulating without Assist .Improper Footwear . Review of Resident #11's Post Fall Evaluation dated 12/13/1033 at 5:47 AM, revealed .Wheelchair was involved in fall. Wheelchair was not locked at time of fall .Footwear at time of fall: Bare feet .Resident was not using cane/walker as instructed .Resident was using incontinent supplies at time of fall. Incontinent at time of fall: Yes. Bedside call light on when Resident was found: No . Review of the FALL COMMITTEE MEETING dated 12/13/2023, for Resident #11 revealed .INTERVENTION: Offer toileting @ [at] HS [hours of sleep] and upon rising . Review of the revision to Resident #11's care plan dated 12/14/2023 revealed the intervention for falls was, . 12/14/2023 Anti-rollbacks to w/c [wheelchair] . Review of the facility's Un-witnessed [Fall Report], for Resident #11's Fall #2, dated 12/18/2023 at 2:16 PM, revealed .observed her [Resident #11] laying on the floor .Resident states she was trying to put away her clothes that were in the basket. She said had one hand on the basket and the other on the walker and fell over the walker .Confused .Gait Imbalance .Improper Footwear .Using [NAME] . Review of the FALL COMMITTEE MEETING dated 12/18/2023, for Resident #11 revealed INTERVENTION: Encourage family to put away laundry once returned . Review of the revision to Resident #11's care plan dated 12/18/2023 revealed, . Encourage family to put away laundry when brought . Review of Resident #11's Un-witnessed [Fall Report], for Fall #3, dated 12/26/2023 at 4:59 AM, revealed . Resident observed sitting in floor between bed and wheel chair [wheelchair] .Non-skid socks placed on Resident .Resident states she was attempting to get into wheel chair because it was storming outside and slid between the bed and the chair .Confused .Impaired Memory .Ambulating without Assistance .Improper Footwear . Review of the FALL COMMITTEE MEETING dated 12/27/2023, for Resident #11 revealed INTERVENTION: Ensure w/c [wheelchair] is beside Bed for Convivence [convenience] . Review of the revision to Resident #11's care plan dated 12/27/2023 revealed, . Ensure w/c is beside bed for convenience. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Resident #11's Un-witnessed [Fall Report], for Fall #4, dated 2/9/2024 at 5:15 AM, revealed . Resident observed sitting on the floor in her room .Resident was wearing regular socks and no shoes at the time .resident stated she was going to the bathroom .Current UTI (Urinary Tract Infection) .Ambulating without Assistance .Improper Footwear . Review of the FALL COMMITTEE MEETING dated 2/9/2024, for Resident #11 revealed INTERVENTIONS: Bowel and Bladder while awake . Review of the revisions to Resident #11's care plan dated 2/9/2024 revealed, . B&B [bowel and bladder] program q [every] 2 hrs [hours] while awake . Review of the quarterly MDS dated [DATE], revealed Resident #11 scored a 3 on the BIMS, which indicated the Resident was severely cognitively impaired. Resident #11 used a walker and wheelchair for mobility, received moderate assistance for sitting to standing and walking 10 feet, and maximum assistance with bed mobility, transfer, and toileting. Resident #11 was frequently incontinent of bladder, always continent of bowel, was not currently on a toileting program (such as scheduled toileting, prompted voiding or bladder training). The MDS documented the Resident had one fall since the previous assessment. Review of Resident #11's Un-witnessed [Fall Report], for Fall #5, dated 3/5/2024 at 4:39 AM, revealed . Resident sitting on buttocks with feet towards bathroom. Resident states she was trying to go to the bathroom to see what her husband was doing in there .Impaired Memory .Ambulating without Assist . Review of the FALL COMMITTEE MEETING dated 3/5/2024, for Resident #11 revealed INTERVENTIONS: Pressure Alarm [to bed] during sleep hours . Review of the revisions to Resident #11's care plan dated 3/5/2024 Pressure alarm to bed during sleep hours .MD [Medical doctor] to do medication review d/t [due to] increased confusion. Review of Resident #11's Un-witnessed [Fall Report], for Fall #6, dated 4/13/2024 at 4:05 PM, revealed . CNA [Certified Nursing Assistant] tried to transfer resident from toilet to w/c [wheelchair] but resident would not sit in chair. CNA lowered resident to the floor . Review of the FALL COMMITTEE MEETING dated 4/15/2024, for Resident #11 revealed INTERVENTION: Therapy to screen . The facility was unable to provide evidence of a therapy screen. Review of Resident #11's Un-witnessed [Fall Report], for Fall #7, dated 4/17/2024 at 9:50 AM, revealed . went into resident room notice [noticed] her laying on the floor against the door . Review of Resident #11's care plan interventions dated 4/18/2024 revealed, . Nursing staff to re-educate resident on safety awareness during transfers. There was no documentation for Therapy to screen Resident #11 per the Fall Committee interventions. Review of the FALL COMMITTEE MEETING dated 4/18/2024, for Resident #11 revealed INTERVENTION: Refer to MD or NP [Nurse Practitioner] to Assess . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The medical record revealed the NP assessed Resident #11 on 4/19/2024. There were no new recommendations or interventions implemented to prevent Resident #11 from further falls. Review of Resident #11's Witnessed Fall [Fall Report], for Fall #8, dated 5/2/2024 3:30 PM, revealed .CNA entered the room and resident [Resident #11] was standing in the middle of the room. Resident would not sit in w/c . CNA lowered resident to the floor and went for help .Oriented to Person .Confused .Ambulating without Assist . Review of the FALL COMMITTEE MEETING dated 5/3/2024, revealed INTERVENTION: Provide door Alarm to Bathroom door . Review of Resident #11's Un-witnessed [Fall Report], for Fall #9, dated 5/5/2024, revealed .observed resident on the floor .Resident stated she was trying to get some panties .Confused .Gait Imbalance .Recent change in Cognition .Ambulating without Assist . Review of the FALL COMMITTEE MEETING dated 5/6/2024, for Resident #11 revealed INTERVENTION: MD [medical doctor] to perform Med [Medication] Review secondary to increased confusion . The facility was unable to provide evidence of an immediate med review performed for the resident's 5/5/2024 fall. Review of the revisions to Resident #11's care plan dated 5/6/2024, revealed . NP [Nurse Practitioner] to assess resident. There was no documentation to include the intervention of adding a door alarm to the bathroom door until 5 days after the 5/2/2024 fall (on 5/7/2024). There was no evidence of how adding a door alarm to the Resident bathroom door would prevent further falls. Review of Resident #11's Un-witnessed [Fall Report], for Fall#10 dated 5/8/2024, revealed .Called to the room per housekeeping that resident [Resident #11] was on the floor. Observed her [Resident #11] laying on left side. Tried to move resident but she started yelling out. Left resident comfortably on the floor to get more assistance and called for [abbreviation for local emergency medical services (EMS)]] .resident stated she was getting her coat out [of] the closet so they could get out of facility .Resident was sent to [named hospital] .Injuries Observed at Time of Incident .left trochanter (hip) .Left ankle (outer) Level of Pain .7 .Mobility: Ambulatory with assistance . Record review revealed Resident #11 was admitted to the hospital on 5/8/2024 - 5/13/2024 with a Left Fractured Femur. The Resident's family declined surgical intervention and the Resident was discharged back to the nursing facility with a 2-week Orthopedic consult and activities as tolerated. Review of the annual MDS dated [DATE], revealed Resident #11 had a BIMS score of 2, which indicated severe cognitive impairment. Resident #11 had physical behaviors toward others, rejection of care, and behaviors were worse than previous assessment. Two or more fall and one with major injury since the previous assessment. Review of the FALL COMMITTEE MEETING dated 5/9/2024, revealed Intervention: Send to ER for Eval [Evaluation]/[and] Adjust closet rod for easier access of clothes . Review of the revisions to Resident #11's care plan dated 5/9/2024, revealed .The resident is .risk for falls r/t [related to] Confusion, Gait/balance problems, Hypotension, Incontinence, Unaware of safety needs, Vision/hearing problems, Wandering .Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of Progress Notes for Resident #11 dated 5/13/2024 (misdated 5/30/2024), revealed Received report from [city of hospital] hospital @ [[TRUNCATED]

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835 Based on policy review, medical record review, and interview, the facility failed to provide services to meet the behavioral needs and implement effective behavior monitoring for 1 of 4 sampled (Resident #166) residents reviewed for behavioral health needs. The findings include: 1. Review of the facility policy titled Behavioral Health Services, dated 6/2023, revealed .It is the policy of this facility to ensure all residents receive necessary behavioral health services to assist them in reaching and maintaining their highest level of mental and psychosocial functioning .The facility will ensure that necessary behavioral health care services are person-centered .while maximizing the resident's dignity, autonomy, privacy, socialization, independence, choice, and safety .Conditions that are frequently seen in nursing home residents and may require the facility to provide specialized services and supports based upon residents' individual needs, include, but are not limited to: Depression . Anxiety and Anxiety Disorders .The assessment and care plan will include goals that are person-centered and individualized .Monitor the resident closely for expressions or indications of distress .Share concerns with the interdisciplinary team (IDT) to determine underlying causes of mood and behavior changes .Facility staff will implement person-centered care approaches designed to meet the individual goals and needs of each resident .includes non-pharmacological interventions. 2. Review of medical records and facility documentation revealed that Resident #166 was admitted to Named Psychiatric Hospital from 12/6/2023 to 1/4/2024 with diagnoses including Cognitive Social or Emotional Deficit following Cerebral Infarction, Vascular Dementia, and Falls. The psychiatric hospital record revealed, .Patient lives at home with his spouse .hx [history] of Vascular Dementia .Wife reports on 11/28 [2023] .busted the front door, sheriff was called . has been throwing bricks at the wife and the windshield . Medical record review revealed Resident #166 was admitted from the psychiatric hospital to the nursing home facility on 1/4/2024, with diagnoses including Dementia with Behavioral Disturbance, Agitation, Anxiety, and Palliative Care. Review of a Nursing Progress Note on 1/4/2024 at 6:30 PM, revealed Resident #166 was in another resident's room. Resident #166 was also observed going through dressers on the hall containing isolation equipment, prompting staff to remove dressers to an empty room with a closed door. Review of a Nursing Progress Note on 1/4/2024 at 8:03 PM, revealed LPN (Licensed Practical Nurse) B documented that after completing Resident #166's skin assessment, she was walking out of the room when Resident #166 struck her in the back. Resident #166 then began wander the halls. Resident #166 was resistant to redirection and was given PRN Ativan (medication for anxiety) for agitation. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician's Orders revealed .UA [Urine Analysis] with C&S [Culture and Sensitivity] 1/4/2024 .Document adverse behaviors (Target behaviors .) in relation to psych meds prn (as needed) .wander guard to leg as ordered to alert staff of any attempts to elope .weekly skin assessment .document adverse behaviors . Haloperidol 1 mg (milligram) two times a day for agitation/anxiety .Haloperidol 2 mg at bedtime for agitation/anxiety .Lorazepam (medication for anxiety) 1 mg every 4 hours as needed for anxiety . Review of a Nursing Progress Note on 1/5/2024 at 1:37 PM, revealed Resident #166 was wandering the halls and going into other resident's rooms. Review of a Nursing Progress Note on 1/5/2024 at 9:49 PM, revealed Resident #166 threw his supper tray on the floor. Resident #166 wandered into other residents' rooms and was discovered going through other residents' belongings. Redirection was unsuccessful. Review of a Nursing Progress Note on 1/6/2024 at 1:26 PM, revealed Resident #166 was observed walking in the hallway while naked, and at 6:38 PM, Resident #166 was found in Resident #52's occupied room, had briefs pulled down to his knees, and was displaying sexually inappropriate behaviors to Resident #52's walker. When the Certified Nursing Assistant (CNA) E attempted to redirect Resident #166 back to bed, Resident #166 grabbed CNA E's arm and told her he was going to break it. He then grabbed her (CNA E) by the throat and told her he was going to kill her. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #166 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated he had severe cognitive impairment and was dependent on staff for all care. Review of a Nursing Progress Note on 1/10/2024 at 10:59 PM, revealed a Hospice CNA attempted to give Resident #166 a shower and he was trying to touch her (Hospice CNA) breasts and buttocks and tried to kiss her. Review of a Nursing Progress Note on 1/11/2024 at 6:09 PM, revealed Resident #166 overturned the chair and bedside table in his room, urinated on the floor, and dumped the water pitcher on the floor. While staff was cleaning up the room, Resident #166 sat in the lobby to watch TV, and tipped over the table in the lobby. Review of a Nursing Progress Note on 1/13/2024 at approximately 7:00 PM, revealed Resident #166 was found in Resident #23's room lying in the bed asleep next to Resident #23. Review of a Nursing Progress Note on 1/14/2024 at 5:13 PM, revealed Resident #166 wandered into the Activity Room and had to be redirected by LPN B after being observed with both hands on another resident's head. Resident #166 was documented to have behaviors from admission on 1/4/2024 until discharge on [DATE]. The behaviors included wandering the halls, going into other resident's rooms, rummaging through other's belongings and Personal Protective Equipment (PPE) carts on the hall, yelling, cursing, disrobing, and grabbing staff. Resident #166 was prescribed antipsychotic, antidepressants, and anxiety medications which were ineffective in controlling behaviors. (continued on next page)

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F 0741

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of Care Plan dated 1/18/2024, after Resident #166 was discharged , revealed .The resident has behavior problems: entering other residents room, rummaging, spitting, agitation, anxious/restlessness, wandering, grabbing others, hitting others, kicking others, pushing others, physically aggressive towards others, exit seeking, expressing anger at others, screaming at others, threatening others, disrobing in public, public sexual acts, throwing/smearing food, delusions, hallucinations, panic, withdrawn .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes .wander guard to leg as ordered to alert staff of any attempts to elope .Administer Depakote (medication for seizures), Haloperidol (medication for agitation), Seroquel (medication for depression), Zoloft (medication for social anxiety) as ordered. Monitor for side effects/effectiveness. Notify MD (physician) as needed .The resident has impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia, BIMS, inattention, disorganized thinking, wandering, and behaviors . The resident has delirium or an acute confusional episode r/t BIMS, inattention, disorganized thinking .Provide medications to alleviate agitation as ordered by MD [Medical Doctor]. Monitor/document side effects and effectiveness .

During an interview on 6/27/2024 at 2:53 PM, LPN B stated, .I can't remember much about him [Resident #166]. LPN B stated that Resident #166 wasn't in the facility very long and that she couldn't remember any behaviors. LPN B confirmed she did find him in Resident #23's bed but that Resident #23 was under the covers and Resident #166 was laying down asleep, on top of the covers next to Resident #23. LPN B was asked if she knew who the resident was that Resident #166 was documented to have .both hands on another resident's head . LPN B stated she could not remember.

During an interview on 6/28/2024 at 8:30 AM, CNA E was asked to describe the incident of Resident #166 grabbing her (CNA E) arm and throat and threatening her. CNA E stated, .he [Resident #166] was going in and out of resident rooms and I found him in another resident's [Resident #52] room with his brief down to his knees and had grabbed the other resident's [Resident #52] walker and started to [display sexually inappropriate behavior] .The resident [Resident #52] was upset and used a pillow and tried to cover him [Resident #166] up. CNA E stated she tried to redirect him and pulled up his brief, but he was very agitated and kept pulling away from her. CNA E stated she was walking Resident #166 down the hallway and the resident was very agitated, .grabbed my arm as hard as he could and said he was going to break if off . CNA E stated Resident #166 then grabbed her (CNA E) by the throat and .said he was going to [F word expletive] kill me . CNA E stated at this point she (CNA E) was very upset, . I just dropped everything and walked out . CNA E stated she told the charge nurse what had happened and that she (CNA E) was told to write a statement and chart the behaviors. CNA E stated, .I wrote the statement .I think I may have just left it at the nurse station, but I don't believe I charted the behaviors .I can't remember .it was all such a blur after that . CNA E stated no one came to interview her or talk about the incident.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/28/2024 at 10:56 AM, the Director of Nursing (DON) stated she had not heard about Resident #166 displaying sexually inappropriate behaviors with a walker in an occupied resident room. The DON confirmed she had heard about Resident #166 becoming physically aggressive with a CNA who was attempting to redirect during behaviors. The DON stated she had heard about the incident when Resident #166 was found in another resident's bed but stated her understanding was that Resident #166 was stopped before he could actually get into the bed. The DON stated, .he [Resident #166] was a handful .wandered . very agitated .hard to redirect . The DON was then asked what interventions were put into place. The DON stated, . we referred him [Resident #166] to psych services .tried redirection .notified the doctor .PRN Ativan for his agitation . The DON was asked if she felt like adequate interventions were put into place to keep staff and resident's safe. The DON stated, .In hindsight, probably not .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49311 Based on policy review, review of the medical record, Controlled Substance Inventory Record review, and interview, the facility failed to ensure the proper reconciliation of controlled medications when 1 of 4 nurses (Licensed Practical Nurse (LPN C) failed to sign out controlled medications on the Controlled Substance Inventory Record and keep a running count of medications on hand. The findings include: 1. Review of the facility's policy titled, Narcotic Control dated 8/2023, revealed .Each time a controlled medication is administered, the nurse must complete the Controlled Substance Inventory Record and keep a running count of medications used and medications on-hand .Verification of the quantities of controlled substances must be recorded on the Controlled Dosage System -Controlled Substance -Shift Change Count Check Sheet . 2. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses Dementia, Carotid Artery Stenosis, Hypertension, Depression and Generalized Anxiety Disorder. Review of the Physician's Order dated 6/4/2024 revealed .Lorazepam (an anti-anxiety medication) 0.5mg 1 tab three times a day . 3. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses Parkinson's Disease, Diabetes Mellitus, Chronic Kidney Disease, Major Depressive Disorder, and Generalized Anxiety Disorder. Review of the Physician's Orders dated 5/26/2024 revealed Lorazepam 0.5mg 1 tab two times a day . 4. Observation and interview during medication storage review of the [NAME] Hall Med Cart on 6/26/2024 at 2:45 PM, revealed Resident #32's Lorazepam 0.5mg medication card had 29 tabs in the card and the resident's Controlled Substance Inventory Record reflected a count of 30 tabs. When LPN C realized the count was incorrect, she started to sign the medication out on the controlled sheet. LPN C was informed that a copy was needed prior to alteration of documentation. LPN C reported that she administered the medication at 2:00 PM to the resident. Review of Resident #22's Lorazepam 0.5mg medication card had 4 tabs in the card, but the resident's Controlled Substance Inventory Record for Lorazepam had a count of 5 tabs. LPN C confirmed that she should have signed the medications out in the controlled book when administering the medications. During an interview on 6/26/2024 at 3:08 PM, the Director of Nursing (DON) confirmed that nursing staff should sign the medications out on the resident's Controlled Substance Inventory Record as the medications are pulled and administered. The DON confirmed that the narcotic controlled counts should match the number of actual pill count in the medication card.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 49269 Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 2 of 6 medication carts (Northeast Cart and [NAME] Cart) was left unlocked and unattended during medication administration. The findings include: 1. Review of the facility's policy titled Medication Storage undated, revealed .It is the policy of this facility to ensure all medications housed on our premises shall be stored in the pharmacy and/or medication rooms .All drugs and biologicals will be stored in locked compartments .During medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart . Review of the facility's policy titled Medication Administration Policy dated 6/2024 revealed .Medication carts must be kept locked when not in use during medication pass . 2. Observation during medication administration on 6/24/2024 at 4:28 PM, LPN B unlocked the Northeast Medication Cart at the North Hall nurse's station, LPN B walked away leaving the cart unlocked and unattended while she walked down the hall to retrieve a computer mouse off another cart. After LPN B returned to the medication cart, she walked away from the medication cart to answer the telephone at the nurse's station leaving the cart unlocked. LPN prepared medications for Resident #42 and entered the resident's room leaving the medication cart outside the resident's room unlocked and unattended. 3. Random observation on 6/28/2024 at 9:02 AM, the west medication cart was noted unlocked and unattended in the hallway, outside Resident #28's room. LPN A exited Resident #27's room and walked to the medication cart and locked the cart outside Resident #28's room. 4. During an interview on 6/28/2024 at 7:52 AM, the DON confirmed that the medication carts should not be left unlocked and unattended by nursing staff during medication administration.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on review of the job description review, review of the State Licensure Regulations, policy review, medical record review, observation, and interview, the facility Administration failed to provide oversight to monitor and prevent hot water temperatures in resident care areas, failed to ensure a safe environment and adequate supervision to prevent falls, failed to prevent resident to resident abuse, and failed to ensure a resident with behaviors received appropriate care and services for 10 of 63 residents (Resident #17, 36, 40, 41, 43, 44, 52, 55, 166, and 370) residents. The findings include: 1. Review of the undated ADMINSITRATOR JOB DESCRIPTION revealed .Position Purpose .Leads, guides, and directs the operations of the healthcare facility in accordance with local state and federal regulations, standards and established facility policies and procedures to provide appropriate care and services to residents .Plans, develops, implements, evaluates, and directs the overall operation of the facility as well as its programs and activities in accordance with current state and federal laws and regulations . Leads and coordinates .management team meetings to discuss priorities and develop solutions .Knows and understands general nursing practices and procedures .Code of Federal Regulations, Appendix PP State Operations Manual .collaborates with members of the interdisciplinary team .to resolve issues .Promotes . effective communication .Ensures the facility's plan of correction response to any regulatory, inspection survey is completed, adequate, implemented, and timely .Communicates directly with .medical staff, nursing staff .department heads, and members of the interdisciplinary team to coordinate care .Responds and resolves complaints and concerns .Protects residents from abuse .Follows established infection control policies . Review of the undated DIRECTOR OF NURSING JOB DESCRIPTION revealed .Position Purpose . Planning, organizing, developing, and directing the overall operations of the Nursing Service Department in accordance with local, state, and federal standards and regulation, established facility policies .to provide appropriate care and services to the residents .Communicates policies and procedures to nursing staff and monitors staff practices and implementations .Participates in daily or weekly management team meetings to discuss .resident change in status, complaints, or concerns .Ensures delivery of .quality care .Oversees resident incidents .daily .reports them promptly to the Administrator .for appropriate action .Monitors for allegations of potential abuse or neglect .and participates in the investigative process .Acts in an administrative capacity in the absence of the administrator . Review of the undated MAINTENANCE DIRECTOR JOB DESCRIPTION revealed .Position Purpose . Directs .Maintenance Department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility and to assure the facility is maintained in a safe and comfortable manner .Ensures proper planning, direction, participation, and supervision of both preventative and unplanned maintenance and repair activities in the facility which includes .plumbing .Develops and implements preventative maintenance tasks .instructions, and procedures for the preventative maintenance of the facility .Ensures the facilities compliance with the law and other regulatory terms such as safety . Performs and monitors required inspections of facility equipment .Maintains a safe and secure working environment free of .situations that could cause harm .to residents, families, visitors . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. The facility Administration failed to ensure the environment was free from accident hazards when dangerously elevated hot water temperatures and failed to provide a safe environment and adequate supervision to prevent falls and injury. a. The facility Administration failed to ensure the environment was free from accident hazards when dangerously elevated hot water temperatures were measured for 8 of 69 (Resident Rooms #13, #17, #18, #86, #89, #90, #91, #93) rooms. On 6/24/2024 and 6/28/2024, dangerous elevated hot water temperatures ranging from 123 degrees Fahrenheit (F) to 130 degrees Fahrenheit (F) were found in 8 of 69 (Resident Rooms #13, #17, #18, #86, #89, #90, #91, #93). Two Residents who were physically and/or cognitively impaired (Residents #43 and #52) resided in a room with elevated dangerous hot water temperatures and two residents were able to access the hot water in their rooms. Two cognitively intact (Residents #40 and #55) stated the water would get too hot. During an interview on 6/24/2024 at 1:22 PM, the Administrator was asked if she was aware there were some problems with the water temperatures last week. The Administrator stated, No ma'am. The Administrator was asked were you notified that there was a problem and the Maintenance Director had to turn up the temperature on the water heater. The Administrator stated, No, not that I recall. The Administrator was asked if they had been notified today that you have water temperatures greater than 120 degrees. The Administrator stated, No ma'am. During an interview on 6/24/2024 at 3:02 PM, The Administrator was asked who monitors water temperatures. The Administrator stated, That would be [named the Maintenance Director]. The Administrator was asked do you expect him to notify you if the water temperatures are out of range. The Administrator stated, Yes. The Administrator was asked are you aware of any problems with the water temperatures. The Administrator stated, No ma'am. The Administrator was asked has [the Maintenance Director] reported any problems with the water temperatures today. The Administrator stated, No ma'am. During an interview on 6/24/2024 at 3:10 PM, the Maintenance Director confirmed there was a problem with the water temperatures the previous week and he had adjusted the water heater. The Maintenance Director was asked when you have a problem like the one last week [with the water temperatures] do you let the Administrator know. The Maintenance Director stated, I try to, but I don't tell her every little thing. During an interview on 6/28/2024 at 9:20 AM, the Administrator confirmed the Maintenance Director had notified her that there was a problem with the water being too hot but did not tell her the temperature of the water. During an interview on 6/28/2024 at 4:11 PM, the Administrator confirmed she had not notified the Medical Director of the Immediate Jeopardy and that the facility had not conducted an ad hoc [when necessary] QAPI [Quality Assurance Performance Improvement] meeting related to the water temperatures. b. The facility Administration failed to provide a safe environment and adequate supervision to prevent falls and injury for 7 of 7 (Resident #2, #11, #21, #28, #46, #52, and #54) sampled residents reviewed for accidents. Resident #11 sustained a fracture of the left distal femur (large upper bone of the leg). (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed the facility failed to conduct fall risk assessments quarterly and after each fall in accordance with the facility policy for Residents #2, #11, #21, #28, #46, #52, and #54) sampled residents reviewed for accidents. During an interview on 6/27/2024 at 3:45 PM, the DON was asked about the fall with Resident #11 when she broke her hip. The DON stated, We have tried nonskid socks, med review, anti-roll backs to wheelchair, family agreed to put clothes in closet and not leave it in basket in floor. We tried to get the family to leave the wheelchair by the bed. We offered toileting at bedtime and upon getting up in mornings .dementia was getting worse. On 3/5 [3/5/2024] the bed alarm was put in place. She has moved rooms now and cannot get up by herself in the room she is in. Are the reminders to call for assistance and educate the resident with a BIMS of 2 appropriate interventions. That should be taken out I don't think she could comprehend to use a call light. Refer to F-689 3. The facility Administration failed to ensure Resident #42's right to be free from abuse when on 1/17/2024, Resident #42 sustained two lacerations to the forehead when Resident #166 hit Resident #42 in the head with a hard plastic drinking cup, resulting in actual HARM. During an interview on 6/28/2024 at 10:56 AM, the Director of Nursing (DON) stated, .he [Resident #166] was a handful .wandered . very agitated .hard to redirect . The DON was asked what interventions were put into place. The DON stated, . we referred him [Resident #166] to psych services .tried redirection .notified the doctor .PRN [as needed] Ativan [a medication for anxiety) for his agitation . During an interview on 6/28/24 at 10:56 AM, the DON was asked if she felt like adequate interventions were put into place to keep staff and resident's safe. The DON stated, .In hindsight, probably not . trying to think of him [Resident #166] particularly with him having issues coming in .we didn't do one on one . outside of putting stop signs on everyone's doors to keep him [Resident #166] from going in there .I don't know what else we could have done .other than he's [Resident #166] leaving and not coming back kind of thing again that's hindsight. That's what we know now . Refer to F-600 4. The facility Administration failed to ensure services to meet the behavioral needs and implement effective behavior monitoring for 1 of 4 sampled (Resident #166) residents reviewed for behavioral health needs. Resident #166 was documented to have behaviors from admission on 1/4/2024 until discharge on [DATE]. The behaviors included wandering the halls, going into other resident's rooms, rummaging through other's belongings and Personal Protective Equipment (PPE) carts on the hall, yelling, cursing, disrobing, and grabbing staff. Resident #166 was prescribed antipsychotic, antidepressants, and anxiety medications which were ineffective in controlling behaviors. In addition to grabbing staff and hitting resident #52 in the head as follows: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER Weakley County Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Weakley County Nursing Home Road Dresden, TN 38225	

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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. A Progress Note dated 1/6/2024 at 1:26 PM, revealed Resident #166 was observed walking in the hallway while naked, and at 6:38 PM, Resident #166 was found in Resident #52's occupied room, had briefs pulled down to his knees, and was displaying sexually inappropriate behaviors to Resident #52's walker. When the Certified Nursing Assistant (CNA) E attempted to redirect Resident #166 back to bed, Resident #166 grabbed CNA E's arm and told her he was going to break it. He then grabbed her (CNA E) by the throat and told her he was going to kill her. b. A Nursing Progress Note on 1/17/2024 at 3:27 PM, revealed Resident #166 entered the room of Resident #42. Resident #166 got Resident #42's cellular phone, and when Resident #42 told resident #166 to put the phone back on the overbed table, Resident #166 struck Resident #42 in the head with a water glass, causing a laceration to the Resident's forehead. On 1/17/2024, after the incident with Resident #42, Resident #166 was discharged back to the Named Psychiatric Hospital. During an interview on 6/28/2024 at 10:56 AM, the Director of Nursing (DON) stated she had not heard about Resident #166 displaying sexually inappropriate behaviors with a walker in an occupied resident room. The DON confirmed she had heard about Resident #166 becoming physically aggressive with a CNA who was attempting to redirect during behaviors. The DON stated she had heard about the incident when Resident #166 was found in another resident's bed but stated her understanding was that Resident #166 was stopped before he could actually get into the bed. The DON stated, .he [Resident #166] was a handful .wandered . very agitated .hard to redirect . The DON was then asked what interventions were put into place. The DON stated, . we referred him [Resident #166] to psych services .tried redirection .notified the doctor .PRN Ativan for his agitation . The DON was asked if she felt like adequate interventions were put into place to keep staff and resident's safe. The DON stated, .In hindsight, probably not . Refer to F-741

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Weakley County Nursing Home	700 Weakley County Nursing Home Road Dresden, TN 38225

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 50780 Based on policy review, observation, and interview, the facility failed to update and revise the Three-Day Disaster Menu to accurately reflect the 3 Day Emergency Food Supply. The findings include: 1. Review of the facility policy titled Emergency Food Supply dated 4/2022, revealed .The Dietary Manager shall maintain a 3-to-7-day supply of nonperishable foods .The emergency food is rotated/replenished every six months . Review of the undated facility policy titled Disaster Planning revealed .Disaster Menu prepared from nonperishable foods. This should include 3 to 7 days depending on state or local requirements .Disaster supplies should be checked routinely . Review of the undated facility policy titled, Three-Day Disaster Menu revealed .Breakfast Day 1 Peanut Butter .Protein Bar .Day 3 Peanut Butter .Protein Bar . 2. Review of the undated facility 3-Day Supply list revealed no supply of peanut butter or protein bars. Observation and Interview in the kitchen on 6/25/2024 at 8:23 AM, revealed the Emergency Food Supply Menu listed peanut butter and protein bars. Observation of Emergency Food Supply revealed that peanut butter and protein bars were not in the Emergency Stock. The Dietary Supervisor confirmed that if food items are on the menu, they should also be in the emergency food supply. During an Interview on 6/26/2024 at 3:34 PM, the Registered Dietician confirmed that if a food item is on the 3-day Emergency Food Supply Menu, it should be included in the 3-day Emergency Food Supply.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445437	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/28/2024
NAME OF PROVIDER OR SUPPLIER	Weakley County Nursing Home	STREET ADDRESS, CITY, STATE, ZIP CODE	700 Weakley County Nursing Home Road Dresden, TN 38225

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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** 47835 Based on policy review, medical record review, observation, and interview, the facility failed to follow Enhanced Barrier Precautions to prevent the spread of infection when 1 of 1 Licensed Practical Nurse (LPN) D failed to wear the correct Personal Protective Equipment (PPE) and when LPN D contaminated the wound during wound care for 1 of 3 (Resident #28) sampled residents for wound care. The findings include: 1. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 5/30/2024, revealed .Enhanced barrier precautions, (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves during high contact resident care activities .an order for enhanced barrier precautions will be obtained for residents with any of the following . chronic wounds such as pressure ulcers .Implementation of Enhanced Barrier Precautions .make gloves and gowns available immediately near or outside of the resident's room .High-contact resident care activities include .wound care .any skin opening requiring a dressing . 2. Review of the medical record revealed Resident #28 was admitted to the facility on [DATE], with diagnoses including Hemiplegia, Carcinoma of Skin, Scalp, and Neck, Dementia, Squamous Cell Carcinoma of Skin, Malnutrition, Depression, and Anxiety. Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed Resident #28 had a Brief Interview for Mental Status score of 6, which indicated she was severely cognitively impaired. Review of the Physician's Orders dated June 2024, revealed no order for Enhanced Barriers. Review of the Physician's Orders dated 6/20/2024, revealed .Cleanse unstageable pressure injury to coccyx with wound cleanser, pat dry, apply calcium alginate (used to absorb excess moisture and promote healing in wound dressings), and cover with foam dressing daily every day shift . Review of the Progress Notes dated 6/19/2024 at 1:35 PM, revealed .Skin/Wound Note .Nurse observed unstageable pressure injury to coccyx .Cleanse unstageable pressure injury to coccyx with wound cleanser, pat dry, apply calcium alginate, and cover with foam dressing daily . During wound care observation on 6/26/2024 at 10:10 AM, revealed LPN D cut a strip of calcium alginate and dropped it onto a contaminated surface. She then proceeded to complete the wound care for Resident #28 using the contaminated calcium alginate. LPN D also did not wear a gown during the wound care. During an interview on 6/28/2024 at 1:40 PM, the Infection Preventionist confirmed staff should wear gown and gloves while performing wound care. During an interview on 6/28/2024 at 1:46 PM, LPN D confirmed she should have worn PPE and disposed of dressing that was contaminated.