

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445446	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/16/2025
NAME OF PROVIDER OR SUPPLIER  Ahc Dyersburg		STREET ADDRESS, CITY, STATE, ZIP CODE 1900 Parr Avenue Dyersburg, TN 38024	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30974</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to treat residents with respect and dignity when 1 of 13 (Certified Nursing Assistant (CNA) G) staff members stood over a resident (Resident #66) to assist with the meal, and when 2 of 13 (CNA M, CNA H) staff members observed during dining failed to use courtesy titles when addressing two residents (Resident #22, #26, and #83).</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Promoting/Maintaining Resident Dignity, dated August 2024, revealed . It is the practice of this facility to protect and promote resident rights and treat each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality .All staff members are involved in providing care to residents to promote and maintain resident dignity and respect resident rights .</p> <p>2. Review of the medical record revealed Resident #66 was admitted to the facility on [DATE], with diagnoses including Heart Disease, Dementia, and Depression.</p> <p>Observation in Resident's #66 room on 1/13/2025 at 12:14 PM, revealed CNA G stood over Resident #66, put food on the utensil, and put it to the resident's mouth to encourage and assist with her lunch meal.</p> <p>During an interview on 400 Hall on 1/13/2025 at 12:27 PM, CNA G was asked, should you have stood over the resident to assist her with her meal. CNA G stated, No, ma'am.</p> <p>Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including Diabetes, Heart Failure, and Depression.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #26 had a BIMS score of 3, which indicated the resident was severely impaired cognition, and required set-up assistance from staff for eating.</p> <p>Observation in Resident #26's room on 1/14/2025 at 7:48 AM, revealed CNA H entered the resident's room set up the resident's meal tray and stated to Resident #26, .You are being sweet today, girl .</p> <p>(continued on next page)</p>		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Central Cord Syndrome Spinal Cord, Quadriplegia, and Atrial Fibrillation.</p> <p>Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed Resident #22 had a Brief Interview for Mental Status score (BIMS) of 15, which indicated the resident was cognitively intact, and required set up for meals.</p> <p>4. Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Diabetes, Hypertension, Alcoholic Cirrhosis of the Liver, Hepatic Encephalopathy, and Epilepsy.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #83 did not have a BIMS score, had short-and-long term memory loss, was severely cognitively impaired, and required supervision for eating.</p> <p>5. Observation during dining on the 300 Hall on 1/13/2025 at 11:48 AM, revealed CNA M removed a tray from the meal cart and pointed to 2 trays left on the meal cart and stated out loud in the hallway, These two are feeders. CNA M was asked who the trays belong to. CNA M stated, [Named Resident #22 and Named Resident #83].</p> <p>During an interview on 1/16/25 at 5:08 PM, the Director of Nursing (DON) confirmed that staff should use courtesy titles when addressing residents and residents should not be referred to as feeders.</p> <p>38439</p> <p>46047</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on medical record review, observation, and interview, the facility failed to ensure a clean, safe, and sanitary environment in 7 of 64 (Resident #2, #12, #13, #30, #36, #51, #53, #54, #57, #62, #72, #73, #78, and #79) resident shared bathrooms when personal hygiene items were found unlabeled and uncontained.</p> <p>The findings include:</p> <p>1. Resident #2 and Resident #72 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Malignant Neoplasm of Nasal Cavity, and Pneumonia.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #2 had a Brief Interview for Mental status (BIMS) score of 9, indicating the resident was moderately cognitively impaired, required assistance with Activities of Daily Living Skills (ADLS), required supervision with toileting hygiene, and was incontinent of both bowel and bladder.</p> <p>b. Review of the medical record revealed Resident #72 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Ulcerative Colitis, Dementia, and Gastroparesis.</p> <p>Review of the annual MDS dated [DATE], revealed Resident #72 had a BIMS score of 11, indicating the resident was moderately cognitively impaired, required moderate assistance with ADLS, and incontinent of both bowel and bladder.</p> <p>c. Observation in Resident #2 and Resident #72's shared bathroom on 1/13/2025 at 9:19 AM, 10:00 AM, and 11:15 AM, revealed the following:</p> <p>A gray wash basin on the back of the toilet unlabeled and uncontained.</p> <p>Four (4) gray wash basins stacked inside of each other on the floor beside the toilet unlabeled and uncontained.</p> <p>A gray bedpan on the floor beside the toilet unlabeled and uncontained.</p> <p>A peach colored toothbrush holder on the sink unlabeled and uncontained.</p> <p>A plunger resting on the floor beside the toilet uncontained.</p> <p>2. Resident #12 and Resident #30 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Chronic Obstructive Pulmonary Disease, Depression, and Malignant Neoplasm of the Large Intestine.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS dated [DATE], revealed Resident #12 had a BIMS score of 3, indicating the resident was severely cognitively impaired, required maximal assistance with toileting, and incontinent of both bowel and bladder.</p> <p>b. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Myocardial Infarction, Atrial Fibrillation, Need for Assistance with Personal Care, and Muscle Weakness.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #30 had a BIMS score of 15, indicating the resident was cognitively intact, required moderate assistance with ADLs, and maximal assistance with toileting.</p> <p>c. Observation in Resident #12 and #30's shared bathroom on 1/13/2024 at 9:29 AM, 10:00 AM, 11:20 AM, and on 1/14/2024 at 8:10 AM, revealed a gray wash basin on the back of the toilet unlabeled and uncontained</p> <p>3. Resident #54 and Resident #57 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident # 54 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Osteomyelitis, and Atherosclerosis.</p> <p>Review of the annual MDS dated [DATE], revealed Resident #54 had a BIMS score of 3, indicating the resident was severely cognitive impaired, and dependent on staff for ADLS and toileting.</p> <p>b. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including Osteomyelitis, Respiratory Failure, Obesity, Muscle Weakness, and Need for Assistance with Personal Care.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #57 had a BIMS score of 10, indicating the resident was moderately cognitively impaired, dependent on staff for ADLS, and incontinent of both bowel and bladder.</p> <p>c. Observation in Resident #54 and #57's shared bathroom on 1/13/2025 at 9:34 AM, 10:14 AM, and 11:55 AM, revealed the following:</p> <p>A gray wash basin on the back of toilet unlabeled and uncontained.</p> <p>A urinal sitting on the assist bar unlabeled and uncontained.</p> <p>4. Resident #13 and Resident #53 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Obesity, Pneumonia, Bradycardia, and Atrioventricular Block.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #13 had a BIMS score of 12, indicating the resident was cognitively intact, dependent on staff for ADLS, and incontinent of both bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE], with diagnoses including Hypothyroidism, Hypertension, Anxiety, and Depression.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #53 had a BIMS score of 15, indicating the resident was cognitively intact, independent with ADLS, and incontinent of both bowel and bladder.</p> <p>c. Observation in Resident #13 and Resident #53's shared bathroom on 1/13/2025 at 9:38 AM and 11:55 AM, revealed the following:</p> <p>A gray bedpan on the floor underneath the sink unlabeled and uncontained.</p> <p>Two gray wash basins on the back of the toilet unlabeled and uncontained.</p> <p>5. Resident #78 and Resident #79 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE], with diagnoses including Compression Fracture of Vertebra, Osteomyelitis, Delirium, Muscle Weakness, Overactive Bladder, and Cognitive Communication Deficit.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #78 had a BIMS score of 9, indicating the resident was moderately cognitively intact, required maximal assistance with toileting, set up for personal hygiene, and continent of both bowel and bladder.</p> <p>b. Review of the medical record revealed Resident #79 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, Macular Degeneration, and Dementia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #79 had a BIMS score of 13, indicating the resident was cognitively intact, required set up for personal hygiene, moderate assistance for toileting, and incontinent of both bowel and bladder.</p> <p>c. Observation in Resident #78 and Resident #79's shared bathroom on 1/13/2024 at 9:43 AM and 11:15 AM, revealed a gray bed pan stacked inside of a gray wash basin on the back of the toilet unlabeled and uncontained.</p> <p>6. Resident #36 and Resident #62 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, Anxiety, Congestive Heart Failure, and Insomnia</p> <p>Review of the annual MDS dated [DATE], revealed Resident #36 had a BIMS score of 3, indicating the resident was severely cognitively impaired, dependent on staff for ADLS, and incontinent of both bowel and bladder.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Hypertension, Osteoporosis, Shortness of Breath, Hearing Loss, and Pneumonia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #62 had a BIMS score of 3, indicating the resident was severely cognitively impaired, dependent on staff for all ADLS, and incontinent of both bowel and bladder.</p> <p>c. Observation in Resident #36 and Resident #62's shared bathroom on 1/13/2025 at 9:44 AM and 11:35 AM, revealed the following:</p> <p>A gray wash basin on the back of the toilet unlabeled and uncontained.</p> <p>A green denture cup on top of the sink unlabeled and uncontained.</p> <p>7. Resident #51 and Resident #73 resided in rooms with a shared bathroom.</p> <p>a. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Diabetes, Quadriplegia, and Neuromuscular Dysfunction of Bladder.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #51 had a BIMS score of 15, indicating the resident was cognitively intact, and dependent on staff for all ADLS.</p> <p>b. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], with diagnoses including Alcoholic Cirrhosis of the Liver, Chronic Obstructive Pulmonary Disease, Respiratory Failure, and Depression.</p> <p>Review of the annual MDS dated [DATE], revealed Resident #73 had a BIMS score of 14, indicating the resident was cognitively intact, required supervision with ADLS, and continent of both bowel and bladder.</p> <p>c. Observation in Resident #51's and Resident #73's shared bathroom on 1/13/2025 at 9:50 AM, 11:45 AM, and on 1/14/2025 at 8:03 AM, revealed the following:</p> <p>A gray wash basin on back of the toilet unlabeled and uncontained.</p> <p>A graduate dispenser on back of the toilet unlabeled and uncontained.</p> <p>A large dark gray bowl sitting on top of the sink unlabeled and uncontained.</p> <p>A clear plastic storage container sitting on top of the sink unlabeled and uncontained.</p> <p>8. During an interview on 1/16/2025 at 5:08 PM, the Director of Nursing confirmed that all personal hygiene items should be placed in plastic bags and stored in the bottom drawer of the residents' bedside table or on the top shelf of the residents' wardrobe and should not be left in the bathroom unlabeled and uncontained. The DON confirmed that all denture cups should be labeled with the resident's name and placed in the top drawer of the bedside table.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30974</p> <p>Based on policy review, medical record review, and interview, the facility failed to revise care plans for 4 of 18 (Resident #12, #38, #80, and #92) resident care plans reviewed for Pressure Ulcers, COVID, Transmission Based Precautions (TBP), and Influenza.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Care Plan Revisions Upon Status Change, dated 12/1/2024, revealed . The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change .The comprehensive care plan will be reviewed, and revised . when a resident experiences a status change .</p> <p>Review of the facility's policy titled, Pressure Injury Prevention and Management, dated 12/1/2024, revealed . The staging of pressure injuries will be clearly identified .the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .Assessments of pressure injuries will be .documented on the Initial and / or Weekly Wound Assessment .the staging of pressure injuries will be clearly identified .interventions will be documented in the care plan .</p> <p>2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, Anxiety, Peripheral Vascular Disease, and Malignant Neoplasm of the Intestine.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #12 had a Brief Interview for Mental Status score (BIMS) of 3, which indicated the resident was severely cognitively impaired, dependent on staff for Activities of Daily Living skills, and incontinent of both bowel and bladder.</p> <p>Review of the Care Plan dated 9/30/2024, revealed no care plan for being at risk, the development, prevention, and treatment of pressure ulcers.</p> <p>Review of a Weekly Wound assessment dated [DATE], confirmed Resident #12 had pressure ulcers to both her left and right heel.</p> <p>Review of the facility's undated Pressure Ulcer list revealed .[Resident #12] .DTPI [deep tissue pressure injury] .L [left] heel .DTPI .R [right] heel .FA [facility acquired] .12/27/2024 .</p> <p>Review of a [Named Wound Care Company] INITIAL WOUND EVALUATION &amp; MANAGMENT SUMMARY, dated 1/14/2025, revealed .Patient presents with wounds on her left heel .right heel .UNSTAGEABLE [DUE TO NECROSIS (dead tissue) OF THE RIGHT HEEL .Etiology .Pressure .Stage .Unstageable Necrosis . Duration .&gt; [greater than] 14 days .UNSTAGEABLE .OF THE LEFT HEEL .Etiology .Pressure .Stage . Unstageable Necrosis .duration .&gt; 14 days .</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in Resident #12's room on 1/15/2025 at 3:30 PM, revealed the Wound Nurse, entered the room, donned PPE (personal protective equipment), removed the dressings to both the right and left heel, and exposed the pressure wounds to the resident's right and left heel. The wounds to the right and left heel were dark brown in color and hard to touch with characteristics of a DTI.</p> <p>The facility failed to revise Resident #12's care plan to prevent or address unstageable pressure ulcers/injuries to the left and right heel.</p> <p>During an interview on 1/16/2025 at 6:20 PM, the Director of Nursing (DON) confirmed the care plan should have been revised to show Resident #12 was at risk, developed, and being treated for pressure ulcers.</p> <p>3. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Urinary Tract Infection, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Muscle Weakness.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #38 had a BIMS score of 14, which indicated the resident was cognitively intact.</p> <p>Review of a Nurses Note dated 1/9/2025, revealed Resident tested positive for covid .isolation .</p> <p>Review of the Care Plan dated 1/16/2025, revealed .The resident has a Respiratory Infection (COVID 19) . Isolation-droplet precautions .Date Initiated .1/16/2025 .Revision on .1/16/2025 .</p> <p>The facility failed to revise the care plan for COVID 19 and Transmission Based Precautions until 1/16/2025, 7 days after Resident #38 tested positive for COVID 19.</p> <p>Review of a Physicians Order dated 1/16/2025, revealed .Infection .COVID 19 .Precautions Type .contact, droplet .Covid Isolation starting 1/9/2025 .</p> <p>Observation during dining on the 200 hall on 1/13/2025 at 12:15 PM, revealed Certified Nursing Assistant (CNA CC) donned PPE (Personal Protective Equipment) and delivered a meal tray to Resident #38. CNA CC confirmed Resident #38 was in isolation due to COVID 19.</p> <p>Observations on the 200 Hall on 1/14/2025 at 7:48 AM and at 5:00 PM, revealed Resident #38 remained in contact / droplet isolation precautions for COVID.</p> <p>During an interview on 1/16/25 at 11:10 AM, the DON and the Infection Control Preventionist (ICP) confirmed that Resident #38 was positive for COVID on 1/9/2025 and has been in Transmission Based Precautions since 1/9/025. The DON confirmed that Resident #38 should have had a care plan developed and revised for infections related to COVID and Transmission Based Precautions.</p> <p>4. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Cellulitis of bilateral lower limbs, Pressure Ulcer of Left Buttock, Diabetes, Influenza, Dementia, Cardiomegaly, and Pneumonia.</p> <p>Review of the admission MDS dated [DATE], Resident #80 had a BIMS score of 6, which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Care Plan dated 10/24/2024, revealed no documentation for Resident #80 being in TBP due to being positive for Influenza.</p> <p>Review of the Nurses' Progress Note dated 1/9/2025, revealed RESIDENT MOVED TO 419A DUE TO POSITIVE FOR THE FLU WILL BE IN DROPLET ISOLATION</p> <p>Resident#80's care plan was not revised to reflect positive for the Flu and droplet isolation.</p> <p>During an interview on 1/16/2025 at 4:05 PM, the DON was asked should Resident #80's care plan have TBP for flu documented. The DON stated, Yes .I don't see it .</p> <p>5. Review of the medical record revealed Resident #92 was admitted to the facility on [DATE], with diagnoses including COVID 19, Neuromuscular Dysfunction of the Bladder, and Abnormal Gait.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #92 had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Review of a Physician's Order dated 1/7/2025, revealed .contact droplet precautions .in room alone.</p> <p>Observation during dining on the 200 hall on 1/13/2025 at 12:25 PM, revealed Certified Nursing Assistant (CNA CC) donned PPE and delivered a meal tray to Resident #38. CNA CC confirmed Resident #92 was in isolation due to COVID 19.</p> <p>Observation on the 200 hall on 1/14/2025 at 7:48 AM and at 5:00 PM, revealed Resident #92 remained in TBP for COVID.</p> <p>During an interview on 1/16/25 at 11:10 AM, the DON and the Infection Control Preventionist (ICP) confirmed that Resident #92 was positive for COVID on 1/5/2025 and has been in TBP since 1/5/2025 and remains in TBP. The DON confirmed that Resident #92's care plan should be revised to reflect infections related to COVID and TBP.</p> <p>38439</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on policy review, medical record review, observation, and interview the facility failed to stage pressure wounds correctly for 1 of 2 (Resident #12) sampled residents reviewed for pressure ulcers.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy titled Pressure Injury Prevention and Management, dated 12/1/2024, revealed .The staging of pressure injuries will be clearly identified .the interdisciplinary team shall develop a relevant care plan that includes measurable goals for prevention and management of pressure injuries with appropriate interventions .Assessments of pressure injuries will be .documented on the Initial and / or Weekly Wound Assessment .the staging of pressure injuries will be clearly identified .interventions will be documented in the care plan .</li> <li>Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Obstructive Pulmonary Disease, Anxiety, Peripheral Vascular Disease, and Malignant Neoplasm of the Intestine.</li> </ol> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was severely cognitively impaired, dependent on staff for ADLs, incontinent of both bowel and bladder.</p> <p>Review of the Care Plan dated 9/30/2024, revealed no care plan for pressure injuries.</p> <p>Review of an Initial Wound assessment dated [DATE], revealed .Non Pressure .Date Wound was Identified . 12/27/2024 .Acquired after admission to facility .Non Pressure .Left heel .Type .Vascular .Length .4.5 x Width 4.5 x Depth .utd [unable to determine] .dark purple .Pain Management Plan .off-loading boots .</p> <p>Review of an Initial Wound assessment dated [DATE], revealed .Date wound was identified .12/27/2024 . Type .Non pressure .Right heel .Type .Vascular .Length .5.0 x Width 5.0 x Depth .utd .dark purple .Pain Management Plan .off-loading boots .</p> <p>Review of a Weekly Wound assessment dated [DATE], revealed .Type of Wound .Non Pressure .Vascular . for the Left and Right Heels.</p> <p>Review of a Weekly Wound assessment dated [DATE], revealed .Type of wound .Non-Pressure .Vascular . for the Left and Right Hells.</p> <p>Review of the facility's undated Pressure Ulcer list revealed .DTPI [deep tissue pressure injury] .L [left] heel . DTPI .R [right] heel .FA [facility acquired] .12/27/2025 .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ahc Dyersburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 Parr Avenue Dyersburg, TN 38024	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a (Named Wound Care Company) INITIAL WOUND EVALUATION &amp; MANAGEMENT SUMMARY, dated 1/14/2025, revealed .Patient presents with wounds on her left heel .right heel .UNSTAGEABLE (DUE TO NECROSIS) OF THE RIGHT HEEL .Etiology .Pressure .Stage .Unstageable Necrosis .Duration .&gt; (greater than) 14 days .UNSTAGEABLE (DUE TO NECROSIS) OF THE LEFT HEEL .Etiology .Pressure . Stage .Unstageable Necrosis .duration .&gt; 14 days .</p> <p>Observation in Resident #12's room on 1/15/25 at 3:30 PM, revealed the Wound Nurse, entered the room and removed the dressings to Resident #12's left and right heels. The right and left heel were both dark brown in color and hardened areas.</p> <p>During an interview on 1/16/25 at 2:51 PM, the Wound Nurse confirmed the wounds on Resident #12's left and right heels were deep tissue injuries and were not vascular.</p> <p>During an interview on 1/16/25 at 5:08 PM, the Director of Nursing (DON) confirmed that in order to classify a wound as vascular that a physician would have to make that diagnosis from a doppler assessment. The DON confirmed that she expects the wound nurse to stage wounds correctly to ensure proper care and treatment of all wounds.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38439</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure an environment free of accident hazards when sharps and hazardous personal items were found in 2 of 66 (Resident #2 and Resident #71) resident occupied rooms.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's undated policy titled, Resident Rights, revealed .Safe Environment .The resident has a right to a safe .environment .</li> <li>Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Hypertensive Heart Disease, Malignant Neoplasm of the Nasal Cavity, and Pneumonia.</li> </ol> <p>Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #2 had a Brief Interview for Mental Status (BIMS) score of 9, indicating the resident was moderately cognitively impaired, and required assistance with activities of daily living skills (ADLs).</p> <p>Observation in Resident #2's room on 1/13/2025 at 9:19 AM, at 10:00 AM, and 11:15 AM, revealed the following items sitting on a wooden bookshelf uncontained and easily accessible:</p> <p>An 8.8 oz (ounce) can of air freshener.</p> <p>An 8 oz can of body spray.</p> <p>An 8 oz bottle of cherry lemonade scented body spray.</p> <p>During observation and interview in Resident #2's room on 1/13/2025 at 11:44 AM, revealed Licensed Practical Nurse (LPN) O was shown the air freshener, the body sprays and was asked how these items should be stored. LPN O confirmed they should be stored in plastic bags, in the resident's drawer and out of reach of residents. LPN O confirmed the items could be hazardous to residents' safety.</p> <p>During an interview on 1/16/2025 at 5:08 PM, the Director of Nursing (DON) confirmed that air freshers and body sprays should not be stored on a shelf and easily accessible to residents, they should be stored in a plastic bag out of reach of residents in the bedside table. The DON confirmed these items are hazards to residents' safety.</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #71 was admitted to the facility on [DATE], with diagnoses including Left Shoulder Effusion, Atrial Fibrillation, and Chronic Obstructive Pulmonary Disease.</li> </ol> <p>Review of the admission MDS assessment dated [DATE], revealed Resident #71 had a BIMS score of 12, indicating the resident was moderately cognitively impaired and required supervision from staff for ADLs. Resident #71 was mobile via wheelchair.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation in Resident #71's bathroom on 1/13/2025 at 10:11 AM, 1/13/2025 at 3:54 PM, and 1/16/2025 at 11:08 AM, revealed an unattended and unsecured disposable razor on the bathroom vanity.</p> <p>During an interview and observation in Resident #71's on 1/16/2025 at 11:18 AM, the Director of Nursing (DON) was asked if the razor should be left in the resident's bathroom unsecured and unattended. The DON confirmed that the razor should not be left in resident's bathroom and should be in the sharp container.</p>		

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<p>F 0732</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Post nurse staffing information every day.</p> <p>38439</p> <p>Based on document review and interview, the facility failed to post the scheduled total number of full-time employees (FTEs) scheduled to work a shift, and their total FTEs hours for 31 of 31 sampled days and failed to post the total actual hours worked by the licensed and unlicensed staff responsible for resident care on the facility's Today's Staffing form for 31 of 31 sampled days.</p> <p>The findings include:</p> <p>Review of the facility's Today's Staffing documents dated 12/9/2024 thru 1/10/2025, revealed the facility failed to complete the number of FTEs scheduled to work and failed to total the number of actual hours worked for licensed and non-licensed staff.</p> <p>During an interview on 1/16/2025 at 8:28 AM, the Scheduler was asked to review the daily staff postings for 12/9/2024 to 1/10/2025 and was asked if they were completed. The Scheduler confirmed they were incomplete and should have included the number of FTEs scheduled, the total hours worked every shift for both licensed and non-licensed staff, and they should reflect any changes due to call-ins.</p> <p>During an interview on 1/16/2025 at 9:55 AM, the Director of Nursing confirmed the daily staff postings were incomplete, should be completed daily to reflect the total FTEs, the total hours worked by both licensed and non-licensed staff members, and should reflect any changes due to call-ins.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50780</b></p> <p>Based on policy review, review of the Pharmacy Products and Services Agreement, medical record review, review of facility drug destruction documentation, and interview, the facility failed to properly document narcotic medications signed in error or wasted, failed to document administration of narcotics on the Medication Administration Record (MAR), failed to identify and report discrepancies for the narcotic count, and failed to ensure drug destruction sheets were signed by a licensed pharmacist for 3 of 4 months ([DATE], [DATE], and [DATE]) of drug destruction documentation reviewed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Review of the facility's policy titled, Medication Administration: Controlled Medications, dated ,d+[DATE], revealed .Provide guidance on promoting safe, high quality resident care, compliant with state and federal regulations regarding monitoring the use of controlled substances .The facility shall have safeguards in place to prevent loss, diversion, or accidental exposure .Controlled substances dispensed from Pharmacy and placed on a non-automated medication cart/refrigerator are sent with a Controlled Drug Receipt/Record Disposition form and once received and place in the cart or cabinet recorded on the Narcotic Control record. Written documentation must be clearly legible with all applicable information provided .The dose noted on the medication record must match the dose recorded on the Medication Administration Record, the controlled Drug receipt/Record/Disposition form and order .The charge nurse or other designee conducts a daily visual audit of the required documentation of controlled substances .Obtaining/Removing/destroying Medications . The entire amount of controlled substances obtained or dispensed is accounted for .When the dosage form dispensed is larger than the dose, the total dose administered, and that portion destroyed is documented to show the total disposition of the drug on the Controlled Drug Receipt/Record/Disposition form Each removal of medication is documented on the Controlled Drug Receipt/Record/Disposition form .Two licensed staff must witness and disposal or destruction of a controlled substance due to waste or refusal and document same on the Controlled drug Receipt/Record/Disposition form .Disposition of Discontinued/Expired Controlled Medications .Controlled substances are destroyed by a consultant pharmacist and the Director of Nursing (DON) or designee .Discrepancy resolution .Any discrepancies which cannot be resolved must be reported immediately as follows .Notify the DON immediately and the pharmacy .Compete an investigation detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted .DON, charge nurse, or designee must also report any loss of controlled substances where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy .Staff may not leave the area until discrepancies are resolved or reported as unresolved discrepancies .</li> <li>2. Review of the facility's policy titled, Pharmacy Products and Services Agreement, dated ,d+[DATE], revealed .Supervision of the records and disposition of a controlled drugs and the maintenance of such records in sufficient detail so as to allow an accurate reconciliation of such controlled drugs .Consulting Services .Monthly narcotic destruction .</li> <li>3. Review of the medical record revealed Resident #57 was admitted to the facility on [DATE], with diagnoses including Low Back Pain and Chronic Kidney Disease.</li> </ol> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Controlled Drug Receipt/Record/Disposition Form revealed Rx# [prescription number] 18857027 Date Dispensed [DATE] .[Resident #57] .Drug/Name/Strength Hydrocodone/APAP [Acetaminophen] [a medication used for pain] ,d+[DATE] MG [Milligram] .Directions TAKE ONE TAB [tablet] BY MOUTH THREE TIMES DAILY .Quantity Dispensed 8 .[Licensed Practical Nurse (LPN) R] .nurse receiving medication .9 Quantity Received [DATE] .Every dose must be accounted for and requires charting on the Medication Administration Record. Disposition of Remaining Doses Quantity Destroyed: 4 .</p> <p>Review of the Physicians Order dated [DATE], revealed Lortab [Hydrocodone/APAP] 5 mg [milligram]-325 mg tablet PRN [as needed] Every 8 Hours for 30 Days .</p> <p>Review of the Controlled Drug Receipt/Record/Disposition Form revealed Rx# 18857027 Date Dispensed [DATE] .[Resident #57] .Drug/Name/Strength Hydrocodone/APAP ,d+[DATE] MG .Directions TAKE ONE TAB [tablet] BY MOUTH THREE TIMES DAILY . Quantity Destroyed: 4 .Date: [DATE] RN [Registered Nurse] Signature [RN A] . Review of the form's administration documentation revealed the following:</p> <p>The medication was signed as being administered on [DATE] and [DATE], with 6 tablets left after the administration on [DATE].</p> <p>On [DATE] at 8:00 PM, one tablet was signed as being administered by RN A, with 5 tablets left.</p> <p>On [DATE] at 8:00 PM, one tablet was signed as being administered by LPN T, with 4 tablets left. The entry was crossed through with 1 line stating, Pulled in error not given, written beside LPN T's entry and marked through with several lines.</p> <p>The number 4 was written below LPN T's entry.</p> <p>Review of the Medication Administration Record (MAR) dated [DATE] revealed 1 dose of Lortab 5 mg -325 mg was administered daily on [DATE] and [DATE].</p> <p>Review of the MAR dated [DATE] revealed no orders for Lortab 5mg-325 mg and no documentation that the medication was administered or attempted to be administered.</p> <p>Review of the Discontinued Narcotic Control Record dated [DATE], revealed ,d+[DATE] [[DATE]] [2:10 PM] . [Resident #57] Hydrocodone/APAP ,d+[DATE] MG TAB .Qty: 4 .RX: 18857027 .Nurse: [LPN R] Nurse: [LPN Z]. 4 Hydrocodone/APAP ,d+[DATE] mg tabs were documented as wasted by a pharmacist and RN A on [DATE].</p> <p>The medication removed from the cart on [DATE] was not documented as given on the MAR, was not documented as wasted and the administration and note that it was pulled in error were both marked out, resulting in improper documentation of whether it was given or wasted. The discrepancy was not identified by the staff who placed the card in the drop box or by the nurse or pharmacy during drug destruction.</p> <p>4. Review of the medical record revealed Resident #258 was admitted to the facility on [DATE], with diagnoses including Open Wound, Left Lower Leg, Peripheral Vascular Disease, and Polyneuropathy.</p> <p>Review of the Physician's order dated [DATE] revealed Gabapentin [a medication used to treat seizures and nerve pain] Capsule 300 MG Give 1 capsule by mouth three times a day .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Controlled Drug Receipt/Record/Disposition Form revealed Rx# 19660408 Date Dispensed [DATE] .[Resident #258] .Drug/Name/Strength Gabapentin Capsule 300 MG .Directions TAKE ONE CAPSULE THREE TIMES DAILY .Quantity Dispensed 60 .[LPN N] .nurse receiving medication 60 Quantity Received [DATE] Date .Every dose must be accounted for and requires charting on the Medication Administration Record. Disposition of Remaining Doses Quantity Destroyed: 36 Date: [DATE] RN Signature [RN A] . Review of the forms administration documentation revealed the following:</p> <p>3 tablets daily are signed out as being administer on [DATE]-[DATE].</p> <p>On [DATE], 2 doses were signed as being administered, with 37 tablets left to count after the second dose.</p> <p>No other doses were signed out as being administered.</p> <p>Review of the MAR dated [DATE] revealed Gabapentin 300 mg was administered 3 times daily on [DATE]-[DATE] and 2 times at 9 AM and 2 PM on [DATE]. The medication was discontinued after the 2:00 PM dose on [DATE].</p> <p>Review of the Discontinued Narcotic Control Record dated [DATE], revealed, XXX[DATE] [2025] 6A [6:00 AM] .[Resident #258] Gabapentin CAP (capsule) 300 MG .Qty: 36 .RX: 19660408 .Nurse: [LPN N] Nurse [RN T] . 36 Gabapentin 300 mg tablets were documented as wasted by a pharmacist and RN A on [DATE].</p> <p>The Controlled Drug Receipt/Record/Disposition Form showed 37 tablets left but 36 tablets were documented as being placed in the drop box and as being disposed of. The discrepancy was not identified by the nurses who placed the medication in the drop box or by the nurse or pharmacist who disposed of the medication.</p> <p>5. Review of the medical record revealed Resident #353 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Restlessness, Agitation, and Dementia.</p> <p>Review of the Physician's Order, dated [DATE], revealed Lorazepam [a medication used to treat anxiety and agitation] .2 mg/mL (milliliters) oral concentrate PRN Every 4 Hours for 30 Days .Take one quarter (0.25) milliliters by mouth every 4 hours, as needed .</p> <p>Review of the Controlled Drug Receipt/Record/Disposition Form revealed Rx# 19232201 Date Dispensed [DATE] .[Resident 353] .Drug/Name/Strength Lorazepam 2MG/ML LIQ [Liquid] CONC [Concentrate] Directions TAKE .(0.25) Milliliters .EVERY FOUR HOURS AS NEEDED .Quantity Dispensed 30.00 ML .[LPN N] .nurse receiving medication 30 ml Quantity Received [DATE] Date .Every dose must be accounted for and requires charting on the Medication Administration Record. Disposition of Remaining Doses Quantity Destroyed: 29 [ML] Date: [DATE] RN Signature [RN A] . Review of the forms administration documentation revealed the following:</p> <p>The medication was documented as being administered on [DATE], [DATE] and [DATE], with 29.25 ml being left after the dose on [DATE].</p> <p>On [DATE] at 8:00 AM, LPN O signed out 0.25 ml with 29 ml left, then drew lines through the entry.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 11:00 AM, LPN O signed out 0.25 ml with 28.75 ml left, then drew lines through the entry.</p> <p>On [DATE] at 4:00 PM, LPN O signed out 0.25 ml with 28.75 ml left, then drew one line through the entry.</p> <p>The word Error and LPN O's initials were written 1 time in large letters beside the 3 entries, instead of beside each entry, on [DATE].</p> <p>The number 29 was written below the third entry made by LPN O, indicating 29 ml was left.</p> <p>There was no documentation of medication being wasted.</p> <p>LPN N documented 29 ml left to count on the right side of the form.</p> <p>Review of the Medication Administration Record, dated [DATE], revealed Resident #353 received 0.25 ml of Lorazepam concentrate 1 time daily on [DATE], [DATE] and [DATE]. There was no other documentation of administration or attempted administration on [DATE].</p> <p>Review of the Discontinued Narcotic Control Record dated [DATE], revealed XXX,d+[DATE] [[DATE]] 7A [7:00 AM][Resident #353] Lorazepam 2MG/ML LIQ CONC Qty: [12 crossed through and 29 ML written below] .RX: 19232201 .Nurse [LPN N] Nurse [RN Q] . 29 ML of Lorazepam was documented as wasted by a pharmacist and RN A on [DATE].</p> <p>The medication removed from the bottle on [DATE] was not documented on the MAR as being offered to the resident or on the Controlled Drug Receipt/Record/Disposition Form as having been wasted. The discrepancy was not identified by the staff who placed the medication in the drop box or by the nurse or pharmacy during drug destruction on [DATE].</p> <p>6. Review of the facility's Discontinued Narcotic Control Record form revealed the Pharmacist and the Nurse should sign and date the bottom of the form.</p> <p>Review of the drug destruction records for [DATE], revealed 1 undated Discontinued Narcotic Control Record form was not signed by the Pharmacist.</p> <p>During an interview on [DATE] at 3:35 PM, Assistant Director of Nursing (ADON) B confirmed she destroyed medications with the pharmacist on [DATE] and did not notice that 1 of the 4 sheets was not signed by the Pharmacist. ADON B confirmed both the Pharmacist and the nurse destroying the medications should sign the Discontinued Narcotic Control Record.</p> <p>During an interview on [DATE] at 9:40 AM, the Director of Nursing (DON) confirmed the Pharmacist and the nurse destroying the medications should sign the Discontinued Narcotic Control Record.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7. During an interview on [DATE] at 2:23 PM, LPN AA confirmed that 2 nurses count narcotics at the beginning and end of each shift, the off going nurse looks at the Controlled Drug Receipt/Record/Disposition Form and calls out the number of pills that should be left on the card or the amount that should be left in the bottle, the oncoming nurse verifies the correct amount of medication is present. LPN AA confirmed if the narcotic count is not correct, the on call (Nurse Manager) should be notified immediately. LPN AA confirmed errors in documentation on the Controlled Drug Receipt/Record/Disposition Form should be crossed out with 1 line and initialed. LPN AA confirmed narcotic medications that are removed from the medication cart but not given are to be wasted, and a second nurse should witness the disposal of the medication and both nurses should document that it was wasted on the Controlled Drug Receipt/Record/Disposition Form. LPN AA confirmed when medications are placed in the narcotic disposal locked box, in the medication room, 2 nurses verify the count on the Discontinued Narcotic Control Record, only nurses have a key to the medication room and to the top portion of the locked box where meds are placed, only ADON B has a key to the bottom portion of the locked box where medications are removed from.</p> <p>During an interview on [DATE] at 2:55 PM, RN A confirmed she assisted the pharmacist with drug destruction on [DATE] and on [DATE]. RN A confirmed she had never assisted with drug destruction prior to [DATE] and was instructed by the pharmacist to look at the Discontinued Narcotic Control Record and verified the count was correct when they called it out for each Resident's medication. RN A confirmed the pharmacist wrote the quantity of the medication destroyed on the Controlled Drug Receipt/Record/Disposition Form after she signed the sheets. RN A confirmed she was not aware of any discrepancies during the drug destruction process. RN A was shown Resident #353's Lorazepam 2MG Controlled Drug Receipt/Record/Disposition Form and confirmed that LPN O had made the 3 entries with lines through them and LPN N had written 29 ml left to count (with 29 ml circled) on the right side of the form. RN A was asked, if the 3 entries made by LPN O were errored out correctly. RN A stated No. RN A confirmed the medication was not documented correctly as having been wasted. RN A was asked, what was the amount left in the bottle after the last dose that was correctly documented was given. RN A stated, 29.25 ml. RN A was asked what amount was documented as destroyed. RN A stated, 29 [milliliters]. RN A was asked, according to the amount of medication signed as being administered on the Controlled Drug Receipt/Record/Disposition Form, was the correct amount of medication destroyed. RN A stated, I don't think so. RN A was shown Resident #258's Gabapentin 300 MG Controlled Drug Receipt/Record/Disposition Form and confirmed the quantity left after the last capsule was signed as given was 37 but the quantity destroyed of was 36. RN A confirmed there was a discrepancy in the count of Resident #258's Gabapentin 300 mg. RN A was shown Resident #57's Hydrocodone/APAP ,d+[DATE] MG Controlled Drug Receipt/Record/Disposition Form and confirmed she signed as administering the medication on [DATE] and that the documentation on [DATE] was by LPN T. RN A confirmed there were 5 tablets left after she administered the medication on [DATE]. RN A confirmed the documentation by LPN T on [DATE] showing one tablet was signed as being administered, then crossed through with one line, with Pulled in error not given written to the side and crossed through was not correct documentation. RN A confirmed she was unable to tell from looking at the Controlled Drug Receipt/Record/Disposition Form if the medication on [DATE] had been given or wasted. RN A was shown the MAR dated [DATE] and confirmed there was no documentation Hydrocodone APAP ,d+[DATE] mg was signed out on [DATE] or on [DATE]. RN A was asked should medication be signed out on the MAR when it is given. RN A stated Yes. RN A confirmed there was a discrepancy with Resident # 57's Hydrocodone/APAP ,d+[DATE] mg due to the medication not being signed as given or wasted.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with ADON B on [DATE] at 3:35 PM, ADON B was shown Resident #353's Lorazepam 2MG Controlled Drug Receipt/Record/Disposition Form and confirmed that the entries made by LPN O on [DATE] were not errored out correctly and the medication was not signed out as being wasted. ADON B confirmed there was a discrepancy in the quantity documented as remaining after the last dose signed out correctly and the quantity being destroyed. ADON B was shown Resident #258's Gabapentin 300 MG Controlled Drug Receipt/Record/Disposition Form and confirmed the quantity left after the last capsule was signed as given was 37 but the quantity destroyed of was 36. ADON B confirmed there was a discrepancy in the count of Resident #258's Gabapentin 300 mg. ADON B was shown Resident #57's Hydrocodone/APAP , d+[DATE] MG Controlled Drug Receipt/Record/Disposition Form and confirmed she was unable to tell from looking at the form if the medication removed from the cart had been given or wasted on [DATE]. ADON B was shown the MAR dated [DATE] and confirmed there was no documentation Hydrocodone APAP , d+[DATE] mg was signed out on [DATE] or on [DATE]. ADON B confirmed medications should be signed out on the MAR after they are administered. ADON B confirmed there was a discrepancy in the count of Resident #57's Hydrocodone/APAP ,d+[DATE] mg. ADON B confirmed she usually wastes medications with the pharmacy but did not assist on [DATE] and [DATE]. ADON B confirmed the pharmacist looks at the actual medication and the Controlled Drug Receipt/Record/Disposition Form, she looks at the Discontinued Narcotic Control Record and confirms the quantity the pharmacist calls out. ADON B confirmed the discrepancies with the medications should have been identified by staff placing medications in the locked box or during drug destruction. ADON B confirmed if medication discrepancies are identified an investigation should be initiated. ADON B was asked if an investigation was initiated to determine the cause of any of these discrepancies. ADON B stated, It doesn't look like it.</p> <p>During an interview on [DATE] at 9:40 AM, the DON confirmed she was not notified until [DATE] about the discrepancies with drug destruction on [DATE] and [DATE]. The DON confirmed 2 nurses count narcotics each shift and 2 nurses verify the count when placing them in the drug destruction lock box for disposal. The DON confirmed the quantity documented as being left and the quantity documented as being destroyed did not match on Resident #258's Gabapentin 300 mg. The DON confirmed medication was errored out incorrectly or not documented correctly as being wasted on Resident #57's Hydrocodone/APAP ,d+[DATE] MG Controlled Drug Receipt/Record/Disposition Form and Resident #353's Lorazepam 2MG Controlled Drug Receipt/Record/Disposition Form. The DON confirmed Hydrocodone /APAP ,d+[DATE] mg was not documented as administered or wasted on Resident #57's [DATE] MAR. The DON confirmed Gabapentin 300 mg was not documented as given after 2:00 PM on [DATE] on Resident #258's [DATE] MAR. The DON confirmed Lorazepam 2mg was not documented as being wasted or administered on [DATE] on Resident #353's [DATE] MAR. The DON was asked should staff have identified these discrepancies during narcotic count, when placing them in the drug destruction box, or during the drug destruction process. The DON stated, Yes. The DON was asked, should you be notified as soon as discrepancies are identified. The DON stated, Yes .</p>		

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NAME OF PROVIDER OR SUPPLIER  Ahc Dyersburg		STREET ADDRESS, CITY, STATE, ZIP CODE  1900 Parr Avenue Dyersburg, TN 38024	
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>38439</p> <p>Based on policy review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 1 staff member (Wound Nurse) left the treatment cart unlocked, unattended, and out of sight.</p> <p>The findings include:</p> <p>Review of the facility's policy Medication Storage, dated 12/1/2024, revealed .All drugs and biologicals will be stored in locked compartments .medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls .Only authorized personnel will have access to the keys to locked compartments.</p> <p>A random observation and interview on the 300 hall on 1/16/2025 at 2:50 PM, revealed an unlocked, and unattended treatment cart. The Director of Nursing (DON) was coming up the hall and was asked, are there medications on this treatment cart. The DON stated, Yes. The DON was asked should the cart be left unlocked and unattended. The DON stated, No.</p> <p>Observation and an interview on the 300/400 hall, at the treatment cart on 1/16/2025 at 5:50 PM, revealed a 0.50 ounce (oz) tube of Medihoney (medication to debride pressure wounds), a 56.7 oz tube of B &amp; C wound dressing (medication used to treat wounds), one pair of nail clippers, a 4oz tube of hydrogel (medication to treat pressure wounds), a 0.22 gram tube of Mipircron ointment (medication used to treat hard to heal wounds), and a 15 gram bottle of Nyamyc topical powder (used to treat wounds with fungus and yeast). The Wound Nurse was asked are these medications used for wounds and skin issues. The Wound Nurse stated, Yes, they are .</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46047</p> <p>Based on policy review, record review, job description review, and interview, the facility failed to ensure comprehensive nutritional assessments were completed timely by a dietitian for 2 of 3 (Resident #256 and Resident #259) residents reviewed for new admissions.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy titled, Nutritional Management, dated 12/1/2024, revealed .The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall conditions .A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission .</li> </ol> <p>Review of a Registered Dietitian job description undated and unsigned revealed .Major Duties and Responsibilities .Provides registered dietitian services in one or more sites according to policies and procedures, and federal and state requirements. Plans, organizes, develops, and directs the nutritional care of the resident in accordance with current federal, state, and local standards, guidelines, and regulations. Assesses/Monitors the residents' nutritional status and provides recommendations to clinical/medical staff. Completes nutritional assessments on residents .</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #256 was admitted on [DATE], with diagnoses including Diabetes, Chronic Obstructive Pulmonary Disease, and Dependence on Renal Dialysis.</li> </ol> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 4, which indicated Resident #256 was severely cognitively impaired.</p> <p>Review of the medical record revealed the facility failed to complete a comprehensive nutritional assessment within 72 hours of admission for Resident #256 until 1/16/2025, 6 days after admission.</p> <ol style="list-style-type: none"> <li>Review of the medical record revealed Resident #259 was readmitted to the facility on [DATE], with diagnoses including Protein-Calorie Malnutrition, Toxic Encephalopathy, and Respiratory Failure.</li> </ol> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #259 was cognitively intact.</p> <p>Review of the medical record revealed the facility failed to complete a comprehensive nutritional assessment within 72 hours of admission for Resident #259 until 1/16/2025, the 8th day after admission.</p> <p>During an interview on 1/13/2025 at 8:52 AM, the uncertified Director of Dietary (DD) confirmed the former Registered Dietitian quit after Christmas. The DD was asked who supervises her since she was not certified. The DD stated, No one, I am on my own.</p> <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 1/15/2025 at 3:40 PM, the Director of Nursing (DON) confirmed that the former Registered Dietitian's last day of employment was 12/27/2024 and that the new Dietitian (working remotely) started on 1/13/2025. The DON confirmed that Resident #256 and Resident #259 did not have a comprehensive nutritional assessment completed within 72 hours of admission or readmission.</p> <p>49311</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49311</p> <p>Based on policy review, observation, and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by a dirty ice machine. The facility had a census of 88 residents.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Ice Machines and Portable Ice Carts, dated 12/1/2024, revealed .It is the policy of this facility to ensure that ice machines/carts are working and in proper order, cleaned, and maintained .Ice machines/carts can be prone to microbial contamination due to improper handling or storage of ice, poor cleaning .Proper cleaning, maintenance, and infection control in relation to the ice machines is important to decrease the risk of illness to residents .The ice machines will be cleaned at any time contamination may have occurred or when visibly soiled .</p> <p>2. During an interview on 1/14/2025 at 11:07 AM, the Dietary Director (DD) stated the cleaning/maintenance of the ice machine was contracted with an outside company. The DD was asked who in the facility was responsible for the ice machine. She stated, I am.</p> <p>Observation of the ice machine located in the Activity Room on 1/14/2025 at 1:18 PM and 2:35 PM, revealed a white chalky substance dripping down the left and right sides of the machine, and down the cart the ice machine was sitting on.</p> <p>During an interview on 1/14/2025 at 2:39 PM, the Administrator confirmed the ice machine should be clean and should not have white chalky substance anywhere on the machine or the cart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30974</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infections when 1 of 14 staff (Certified Nursing Assistants (CNA) G) failed to properly remove their personal protective equipment (PPE) during dining services, when 2 of 15 staff (CNA F and Certified Occupational Therapist Assistant (COTA) BB) failed to properly disinfect reusable resident equipment before exiting an isolation room, and when 2 of 14 staff (CNA H and CNA I) failed to perform hand hygiene during dining.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Routine Cleaning and Disinfection, dated 12/2024, revealed .It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible . Resident chairs .Standard precautions will be adhered to when cleaning any blood or body fluid spills, or soiled material that have the potential to contain these or other potentially contaminated substances .Use of gloves, gown, mask, eye protection or face shield .</p> <p>Review of the facility's undated policy titled, Resident Rights, revealed .Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment .</p> <p>Review of the facility's policy titled, Infection Prevention and Control Program, dated 12/1/2024, revealed . Equipment Protocol .Single use devises must be discarded after use and are never used for more than one resident .Reusable items potentially contaminated with infectious materials shall be placed in an impervious clear plastic bag. Label bag as CONTAMINATED and place in the soiled utility room for pickup and processing .</p> <p>Review of the facility policy titled, Transmission-Based (Isolation) Precautions, dated 12/1/2024, revealed .It is our policy to take appropriate precautions to prevent transmission of pathogen, based on the pathogens' mode of transmission .Droplet precautions refer to actions designed to reduce/prevent the transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions .</p> <p>Review of the facility policy titled, Hand Hygiene, dated 12/2024, .All staff will perform proper hand hygiene procedures to prevent the spread of infection .After handling items potentially contaminated with blood, body fluids, secretions, or excretions .Before applying and after removing personal, protective (PPE), including gloves .</p> <p>2. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Urinary Tract Infection, Acute Kidney Failure, Chronic Obstructive Pulmonary Disease, and Muscle Weakness.</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #38 had a Brief Interview for Mental Status Score (BIMS) of 14, which indicated the resident was cognitively intact.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a Nurses Note dated 1/9/2025, revealed Resident tested positive for covid .isolation .</p> <p>Review of a Physicians Order dated 1/16/2025, revealed .Infection .COVID 19 .Precautions Type .contact, droplet .Covid Isolation starting 1/9/2025 .</p> <p>Review of the Care Plan dated 1/16/2025, revealed .The resident has a Respiratory Infection [COVID19] . Isolation-droplet precautions .Date Initiated .1/16/2025 .Revision on .1/16/2025 .</p> <p>Observation and interview on the 200 hall on 1/15/25 at 8:13 AM, revealed COTA BB, was standing outside of the resident's room and was given a wheelchair from inside Resident #38's room, swiped the arms of the wheelchair and the seat of the wheelchair, walked down the hall with her gloves on, entered the therapy gym, and sprayed the wheelchair with a disinfectant spray and let it stand to dry. The COTA BB was asked should you have cleaned the contaminated chair outside in the hallway. The COTA stated, I wiped a little of it down with the cloth . The COTA confirmed the chair should have been cleaned inside of the resident's room thoroughly prior to pushing the chair down the hallway to the therapy gym.</p> <p>During an interview on 1/16/2025 at 11:10 AM, the Director of Nursing (DON) and the Infection Control Preventionist (ICP) confirmed that Resident #38 was positive for COVIID on 1/9/2025 and has been in Transmission Based Precautions since 1/9/025.</p> <p>During an interview on 1/16/2025 at 7:30 PM, the DON confirmed that reusable resident equipment should be cleaned with an approved disinfectant prior to bringing the equipment out of the resident's room who is in transmission-based precautions. The DON confirmed the wheelchair should have been cleaned in the Resident #38's room prior to being transported down the hallway to the therapy gym.</p> <p>3. Review of the medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Cellulitis of bilateral lower limbs, Pressure Ulcer of Left Buttock, Diabetes, Influenza, Dementia, Cardiomegaly, and Pneumonia.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], Resident #80 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severely impaired cognition.</p> <p>Review of the Physician's Orders dated 1/9/2025, revealed .Droplet isolation for THE FLU .every shift .</p> <p>Observations on the 400 hall on 1/13/2025 at 9:54 AM and 4:59 PM, on 1/14/2025 at 8:20 AM and 4:57 PM, confirmed Resident #80 was in Enhanced Barrier Precautions and should have been in Transmission Based Precautions for influenza.</p> <p>Observation on 400 Hall on 1/13/2025 at 12:12 PM, revealed CNA G applied an isolation gown and gloves prior to entering Resident #80's room with meal tray, exited the isolation room and removed her gown and gloves in the hallway. CNA G rolled up the gown and gloves in her hand and walked down the hall to the shower room to discard of the used isolation gown and gloves.</p> <p>During an interview on 1/13/2025 at 12:26 PM, CNA G was asked where she should have removed her PPE. CNA G stated. In the resident's room.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. Review of medical record revealed Resident #92 was admitted on [DATE], with diagnoses including Anxiety and COVID-19.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #92 had a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Review of the Physician's orders dated 1/11/2025, revealed .Infection: COVID-19 . Precaution Type: droplet .</p> <p>Observation during dining on 1/13/2025 at 12:29 PM, revealed CNA F exited Resident #92's room with goggles on top of her head, and attempted to enter another resident's room, before cleaning her goggles.</p> <p>During an interview on 1/13/2025 at 12:31 PM, CNA F confirmed that she should have removed the goggles before exiting the room.</p> <p>5. Review of the medical record revealed Resident #49 was admitted to the facility on [DATE], with diagnoses including Diabetes and Acquired Absence of Right Leg Above the Knee.</p> <p>Review of the admission MDS dated [DATE], revealed Resident #49 had a BIMS score of 11, which indicated the resident was moderately cognitively impaired.</p> <p>Observation on 1/14/2025 at 7:48 AM, revealed CNA H entered Resident #49's room, picked up the bed remote to raise the bed, repositioned the resident, picked up a breakfast sandwich with her bare hands, and handed it to Resident #49. CNA H failed to perform hand hygiene after touching a potentially contaminated items and failed to apply gloves before picking up the resident's food and serving it to a resident.</p> <p>6. Review of the medical record revealed Resident #5 was admitted to the facility 7/30/2021, with diagnoses including Diabetes and Dementia.</p> <p>Review of the quarterly MDS dated [DATE], revealed Resident #5 had a BIMS score of 3, which indicated the resident was severely cognitively impaired.</p> <p>Observation on 1/14/2025 at 8:03 AM, revealed CNA I entered Resident #5's room, picked up and moved a floor mat to the other side of the room, and failed to perform hand hygiene. CNA I then removed Resident #5's lid from the plate, put sugar in the resident's coffee and cut up the resident's food. CNA I failed to perform hand hygiene after touching potentially a contaminated item and before setting up the resident's meal tray.</p> <p>During an interview on 1/16/2025 at 7:52 PM, the DON stated .Reusable equipment should be cleaned thoroughly before exiting a resident's room [isolation], then allowed to dry before transporting to a clean area .</p> <p>During an interview on 1/16/2025 at 5:43 PM, the DON confirmed staff should not use their bare hands to pick up the resident's food, should use gloved hands to pick up the resident's food, and perform hand hygiene before and after applying gloves.</p> <p>(continued on next page)</p>		

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F 0880	38439
Level of Harm - Minimal harm or potential for actual harm	46047
Residents Affected - Some	49311