STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445452	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc McNairy County	835 East Poplar Avenue Selmer, TN 38375

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to follow Physician's Orders related to urology referrals and failed to obtain an order for Percutaneous Endoscopic Gastrostomy (PEG) site care for 2 of 6 residents (Resident #21 and #33) sampled residents reviewed for hospitalizations and PEG feedings. The findings include: 1. Review of the facility policy titled, Enteral Feedings- Safety Precautions, dated November 2018, revealed .Purpose .To ensure the safe administration of enteral nutrition .Assess for leaking around the gastrostomy.with each feeding or medication administration.observe for signs of skin breakdown, infection and irritation.Document all assessments, findings and interventions in the medical record. 2. Review of the medical record revealed Resident #21 was readmitted on [DATE], with diagnoses including Hydronephrosis, Renal and Ureteral Calculous Obstruction (occurs when a kidney stone gets lodged in the tube that carries urine from the kidney to the bladder, Urogenital Implants (medical devices used to address urinary or genital problems), Urinary Tract Infection, Bacteremia (the presence of viable bacteria in the bloodstream), Sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), and Acute Kidney Failure. Review of the progress note dated 6/16/2025, revealed Resident #21 was transferred to the hospital on 5/31/2025 with progressive weakness, poor appetite, and mental status changes. He was found to have a kidney stone and kidney infection with sepsis. He underwent a medical procedure to remove the stone, and a stent was placed in his ureter (tube that carries urine from the kidney to the bladder) on 6/1/2025. He was diagnosed with Sepsis with acute renal failure and renal cortical necrosis (when the small arteries supplying blood to the outer layer of the kidney are injured). Review of the progress note dated 6/16/2025, revealed .N.O. [New Order] per [named Doctor] to refer to a urologist. Stated to hold off on other referrals hospital recommended at this time. To set up appt [appointment] tommorrow [tomorrow] . Review of the Physician's Orders dated 6/17/2025, revealed .Referral to Urologist s/p [status post] stent placement one time only for ureter Stent for 2 Days. Review of the progress note dated 6/18/2025, revealed .called [named Doctor] office .re [regarding]: need for appointment-spoke with [named staff] -states that resident will be a new patient and they will need a referral first-states that she will fax referral papers .as requested-awaiting referral papers . Review of the Care Plan dated 5/29/2025, revealed the care plan was not revised to reflect Resident #21's current medical status. Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident #21 was moderately cognitively impaired. During an interview on 7/22/2025 at 5:11 PM, Registered Nurse (RN) C confirmed that an appointment with urology was never made for Resident #21. During an interview on 7/23/2025 at 2:21 PM, the MDS Coordinator RN confirmed that the Care Plan should have been revised to reflect the resident status post hospitalization. During an interview on 7/23/2025 at 4:11 PM, the Director of Nursing (DON) confirmed the urology appointment should have been made and stated, .the ball got dropped. 3. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Hemiplegia and Hemiparesis, Diabetes Mellitus, Mild Protein-Calorie Malnutrition, and Dysphagia. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 11, which indicated Resident #33 had moderately impaired cognition, was dependent on staff for Activities of Daily Living (ADLs), and had a feeding tube (PEG). Review of the Physician's Orders for May, June, and July 2025, revealed no order for PEG site care. Review of the Treatment Administration Record (TAR) for May, June, and July 2025, revealed no treatment for PEG site care was completed. During an interview on 7/23/2025 at 8:32 AM, Licensed Practical Nurse (LPN) B confirmed there was no order for PEG site care and there should have been. LPN B was asked how staff would be aware of the need to perform care if it was not ordered. LPN B stated, .I would hope that they know to do it. Observation of Resident #33's PEG site on 7/23/2025 at 9:11 AM, revealed an undated 4x4 split gauze to area. The PEG site was clean and dry. During an interview on 7/23/2025 at 10:31 AM, the DON was asked who performs PEG site care and how do they ensure it is completed. The DON stated, .It will be signed off on the TAR.The nurse does it .they should do it daily . The DON confirmed there was no order for PEG site care and there should have been an order.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, Care Path Fall guideline, medical record review, observation, and interview, the facility failed to document falls, implement fall interventions, and conduct a neurological assessment for 1 of 2 (Resident #4) sampled residents reviewed for falls. The findings include: 1. Review of the facility policy titled, Neurological Assessment (Routine), dated 10/2023, revealed The purpose of the procedure is to provide guidelines for conducting a routine neurological assessment (neuro checks).Routine neurological assessment is conducted to evaluate the resident for small changes over time that may be indicative of neurological injury. Routine neurological exams include assessing.mental status and level of consciousness.pupillary response. motor strength.sensation.gait.The following information should be recorded in the resident's medical record. The date and time the procedure was performed.The name and title of the individual(s) who performed the procedure.All assessment data obtained during the procedure.If the resident refused the procedure, the reason(s) why and the intervention taken.The signature and title of the person recording the data. Review of the facility policy titled, Falls and Fall Risk, Managing, dated 12/2007, revealed Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.staff will identify and implement relevant interventions. Review of the CARE PATH Fall guideline signed by the Medical Director on 1/21/2025, revealed .Monitor Neuro checks x [times] 24-72* [hours]. 2. Review of the medical record revealed Resident #4 was readmitted to the facility on [DATE] with diagnoses including Dementia, Acquired Absence of Right Leg Above Knee, Acquired Absence of Left Leg Above Knee, and Depression. Review of the Physician's Orders for Resident #4 dated 5/14/2025, revealed .Bed pressure pad alarm when in bed to alert staff of residents attempts to rise unassisted. every shift.Chair/clip alarm while up in chair due to fall risk every shift. Review of the Incidents By Incident Type report dated 4/21/2025-7/21/2025, revealed .Un-witnessed Fall Incidents. on 5/23/2025, 5/26/2025, 6/4/2025, 6/20/2025, 6/23/2025, 7/7/2025, 7/16/2025, and 7/20/2025 for Resident #4. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #4 was moderately cognitively impaired with no behaviors. Resident #4 required partial/moderate staff assistance with bed mobility, substantial/maximal staff assistance with sit to lying, and was dependent upon staff with lying to sitting and transfers. Review of the Nurse's Note dated 5/26/2025, revealed .CALLED TO ROOM AND OBSERVED RESIDENT SITTING ON HIS BOTTOM IN THE FLOOR IN BETWEEN THE TWO BEDS, HE DIDNT KNOW HOW HE SAT IN THE FLOOR. HE THOUGHT HE WAS GETTING HIS WHEELCHAIR . There was no documentation in the medical record that a neurological assessment was conducted for Resident #4's fall on 5/26/2025. Review of the comprehensive care plan dated 5/27/2025, revealed .ASSESS FOR CHAIR/BED ALARM-applied Date Initiated: 2/1/2025 Revision on: 7/8/2025 .Bed alarm to bed, tab alarm when up in chair Date Initiated: 3/15/2025 Revision on: 7/8/2025 . education given to staff to put the bed alarm under bed sheet on top of mattress Date Initiated: 3/17/2025 Revision on: 7/8/2025.inservice staff to ensure bed alarm is in place Date Initiated: 6/23/2025 Revision on: 7/8/2025 . STAFF IN SERVICED TO USE BED PAN WHEN RESIDENT STATES HE NEEDS TO HAVE A BOWEL MOVEMENT AND TO REMOVE HIS BRIEF AND BOTTOM CLOTHING. STAFF ALSO IN SERVICED TO MAKE SURE THAT BED ALARM WAS ON BED,UNDER [BED, UNDER] RESIDENT AND IN WORKING ORDER WHEN HE IS IN BED. Date Initiated: 7/21/2025. There was no Nurse's Note documenting Resident #4's fall on 6/4/2025. There was no Nurse's Note documenting Resident #4's fall on 7/16/2025. Review of the Nurse's Note dated 7/20/2025, revealed .CNA [Certified Nursing Assistant] CALLED THIS NURSE TO RESIDENTS [Resident #4's] ROOM AND RESIDENT SITTING IN FLOOR IN FRONT OF WHEEL CHAIR FULLY CLOTHED ASKING TO FOR HELP [asking for help]. RESIDENTS BED ALARM DID NOT SOUND AS RESIDENT HAD BEEN IN BED HAVING A BOWEL MOVEMENT . Observation in Resident #4's room on 7/22/2025 at 3:35 PM, revealed Resident #4 was seated in the wheelchair (w/c) with a chair/clip alarm attached to the back of the w/c with alarm clip attached to the alarm strap, not the resident's clothing and no bed pressure alarm was present on the bed. During an interview on 7/22/2025 at 3:52 PM, Licensed Practical Nurse (LPN) E confirmed Resident #4's chair/clip alarm was not attached properly and that it should be attached to the resident's clothing. LPN E was asked if Resident #4 uses a bed pressure alarm when in bed. LPN E stated, I'm not sure. LPN E asked CNA F if Resident #4

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview the facility failed to obtain a Physician's Order for catheter care and failed to provide catheter care for 1 of 1 sampled resident (Resident #27) reviewed for indwelling urinary catheter. The findings include: 1. Review of the facility policy titled, Catheter Care, Urinary, dated August 2022, revealed .The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.Use a washcloth with warm water and soap (or clean bathing wipe) to cleanse the labia [folds of skin around the vaginal opening] Use one area of the washcloth (or wipe) for each downward, cleansing stroke.Change the position of the washcloth (or wipe) and cleanse around the urethral meatus [the opening of the urethra, a tube that carries urine from the bladder to the outside of the body]. Do not allow the washcloth/wipe to drag on the resident's skin or bed linen.With a clean washcloth (or wipe), rinse using the above technique.The following information should be recorded in the resident's medical record.The date and time that catheter care was given.The name and title of the individual(s) giving the catheter care . 2. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Retention of Urine, and Cerebral Infarction [occurs when a lack of blood flow to the brain causes brain cells to die]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #27 was cognitively intact, required assistance with activities of daily living (ADLs), and had an indwelling catheter. Review of the Physician Orders for July 2025, revealed there were no active orders for catheter care. Review of the Treatment Administration Record (TAR) for July 2025, revealed, .B&B [Bowel and Bladder]: Foley catheter Care every shift and prn [as needed].start date.7/2/2025.D/C [discontinued] date.7/11/2025. Review of the TAR dated July 2025, revealed there was no foley catheter care documented after Resident #27's return to the facility on 7/18/2025, following hospitalization for altered mental status (AMS) and urinary tract infection (UTI). Catheter care was not documented for 6 days. During an interview on 7/23/2025 at 8:00 AM, Resident #27 was asked if staff provided catheter care. Resident #27 stated, .I was told catheter care should be performed daily, but it is not always done. Sometimes they do it and sometimes they don't . During an interview on 7/23/2025 at 9:33 AM, LPN A was asked if Resident #27 had an order for catheter care. LPN A was unable to provide an order and confirmed residents with indwelling foley catheters should have an order for catheter care. During an interview on 7/23/2025 at 10:21 AM, the Director of Nursing (DON) was asked about the process to ensure catheter care is provided. The DON confirmed there should be an order for catheter care to be completed and documented daily.