STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445467	A. Building B. Wing	02/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alamo Nursing and Rehabilitation Center	580 W Main Street Alamo, TN 38001

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, observation, and interview the facility failed to ensure a resident was provided Oxygen consistent with professional standards of practice when the facility failed ensure an order for the continued use of Oxygen and failed to monitor and document the effectiveness of the Oxygen, for 1 of 2 resident (Resident #41) sampled for Oxygen. The findings include: 1. Review of the facility's policy titled, Oxygen Administration, dated 4/2014, revealed .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure. Review the physician's order or facility protocol for oxygen administration .Before administering oxygen, and while the resident is receiving oxygen therapy, assess for the following as applicable .Oxygen tubing should be replaced weekly as well as humidifier bottles if not already replaced. It should be labeled with a resident identifier and date .After completing the oxygen setup or adjustment, the following information may be recorded in the resident's electronic medical record: 1. The date and time that the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The rate of oxygen flow and route. 4. The reason for p.r.n. (as necessary) administration. 5. Any assessment data obtained before, during, and after the procedure if applicable 2. Medical record revealed Resident # 41 was admitted to the facility on [DATE], with diagnoses including of Chronic Obstructive Pulmonary Disease, Anxiety, and Peripheral Vascular Disease. Review of the annual Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview for Mental Status score of 15, which indicated Resident #41 had intact cognition. Review of the Physician Orders revealed Resident #41 had no order for Oxygen(O2). Observation in Resident #41's room on 2/10/2025 at 9:40 AM, at 4:51 PM, and 1:47 PM on 2/12/2025 at 8:49 AM, revealed the resident had O2 via nasal canula at 3 Liters. Observation on 2/10/2025 at 1:52 PM revealed the O2 tubing was on Resident #41's dresser, not in a bag. Observation on 2/11/2025 at 4:20 PM revealed the O2 tubing was on the resident's bed, not in a bag. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/12/2025 at 8:55 AM, Practical nurse (LPN H) entered confirmed Resident #41's room and confirmed the resident had O2 via nasal canula set on 3 Liters. LPN H confirmed no awareness Resident #41 received O2, looked in the computer and confirmed Resident #41 had no order for the O2. During an interview on 2/12/2025 at 9:46 AM, the Director of Nursing was asked about orders for Oxygen. The DON stated, .the order should be in the computer .should be monitored . be on the MAR [medication administration record] .checking the O2 sat [saturation] to make sure right amount of O2 . The DON confirmed Resident #41 did not have an order in the computer for Oxygen use, and Resident O2 saturation was not monitored to ensure adequate amount of O2 was delivered to maintain acceptable safe levels.

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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. 30974 Based on policy review, observation, and interview, the facility failed to ensure that medication records were in order and that an account of all controlled medications were maintained and reconciled for 1 of 3 Medication Carts (North Medication Cart) medication carts. The findings include: 1. Review of the facility policy titled Administering Medications, dated 11/2017, revealed .The individual administering the medication .the signature will be attached after giving the medication .As required .for a medication, the individual administering the medication will record in the resident's medical record .The signature and title of the person administering the drug . 2. Observation and interview at the North Medication Cart on 2/11/2025 at 8:52 AM, revealed Licensed Practical Nurse (LPN) B was asked to review Resident #5's narcotics. Review of the NARCOTIC INVENTORY SHEET for Resident #5 revealed, .Tramadol [for pain] 50 MG [milligrams] .Doses Left .2 . Review of Resident #5's narcotic card revealed 1 tablet remained. LPN B was asked about the difference in the number remaining, I did not sign it out she confirmed it should have been signed out when it was administered. Observation and interview at the North Medication Cart on 2/11/2025 at 8:55 AM, revealed Licensed Practical Nurse (LPN) B was asked to review Resident #11's narcotics. Review of the NARCOTIC INVENTORY SHEET for Resident #11 revealed, .Gabapentin [for nerve pain] 300 MG [milligrams] .Doses Left .3 . Review of Resident #11's narcotic card revealed 2 tablets remained. LPN B was asked about the difference in the number remaining, I did not sign it out she confirmed it should have been signed out when it was administered. Observation and interview at the North Medication Cart on 2/11/2025 at 8:58 AM, revealed Licensed Practical Nurse (LPN) B was asked to review Resident #24's narcotics. Review of the NARCOTIC INVENTORY SHEET for Resident #24 revealed, .Lorazepam [for anxiety] 0.5 MG [milligrams] .Doses Left .8 . Review of Resident #24's narcotic card revealed 7 tablets remained. LPN B was asked about the difference in the number remaining, I did not sign it out she confirmed it should have been signed out when it was administered. During an interview on 2/11/2025 at 9:34 AM the Regional Nurse Consultant confirmed that narcotics should be signed out in the narcotic book after they are administered.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, and interview the facility failed to ensure a resident's medication regimen was free of unnecessary medications when the facility failed to ensure as needed (prn) psychotropic medications were discontinued after 14 days, failed to ensure monitoring related to the use of an anticoagulant (blood thinner), and failed to follow a provider's order for 1 of 5 residents (Resident #6) sampled for unnecessary meds. The findings include: 1. Review of the facility's undated policy titled, Psychotropic Medication Use, revealed .A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior . Anti-anxiety medications; and .PRN orders for psychotropic medications are limited to 14 days .For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication . Review of the facility's policy titled, Anticoagulation - Clinical Protocol, dated 2/2014, revealed .The staff and physician will identify and address potential complications .The staff and physician will monitor for possible complications . 2. Review of the medical record revealed Resident # 6 was admitted to the facility on [DATE], with diagnoses including Dementia, Chronic Kidney Disease, Atherosclerotic Heart Disease, Anxiety, and Depression. Review of the annual Minimum Date Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 7, which indicated Resident #6 had severe cognitive impairment and received antidepressants, and antianxiety medications. Review of the Physicians Order dated 10/17/2024, revealed Eliquis [an anticoagulant-blood thinner] Oral Tablet 5 MG [milligrams] (Apixaban) Give 1 tablet by mouth two times a day for PVD [Peripheral Vascular Disease]. Review of the Physician Order dated 11/10/2024, revealed Promethazine [medication for nausea and vomiting] HCl Oral Tablet 25 MG (Promethazine HCl) Give 25 mg by mouth every 8 hours as needed for nausea/vomiting. The as needed Promethazine order had no end date. Review of the Physician Order dated 11/18/2024, revealed Ativan [an antianxiety medication] Oral Tablet 0.5 MG (Lorazepam) .Give 0.5 mg by mouth every 4 hours as needed The as needed order for Ativan had no end date. Review of a Pharmacist Communication/Recommendation sheet revealed [named Provider] signed and dated to discontinue Promethazine (a medication used for nausea and vomiting) on 2/4/2025. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2025 at 10:10 AM, the Director of Nursing (DON) confirmed Resident #6 had an as needed (prn) order for Ativan dated 11/18/2024 with no end date. The DON confirmed a review of the facility's policy would be necessary before questions related to the as needed order for Ativan could be answered. The facility failed to discontinue the prn psychotropic medication order after 14 days and failed to present documented rationales for the continued use of the prn psychotropic medication. The DON confirmed the facility failed to monitor Resident #6 for bleeding and bruising related to the use of Eliquis and it should have been completed every shift. The DON confirmed the facility failed to discontinue Promethazine as ordered by the provider.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review, observation, and interview, the facility failed to ensure a medication administration rate of less than 5% (percent) when 1 of 4 nurses (Licensed Practical Nurse (LPN) B) failed to sign out 19 out of 25 medications after administration for 2 of 2 sampled residents (Resident #30 and #39) observed during medication administration. This resulted in a medication administration error rate of 76%. The findings include: 1. Review of the facility policy titled Administering Medications, dated 11/2017, revealed .The individual administering the medication is logged into the resident's EMR [Electronic Medical Record] the signature will be attached after giving the medication .As required .for a medication, the individual administering the medication will record in the resident's medical record .The signature and title of the person administering the drug . 2. Review of the medical record revealed Resident #30 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Edema, Depression, Glaucoma and Pain. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated that Resident #30 was cognitively intact. Observation in Resident #30's room on 2/11/2025 at 8:21 AM, revealed Resident #30 was administered Trilogy (asthma treatment), Iron (supplement), Gabapentin (nerve pain treatment), Tramadol (pain treatment), Gemtesa (overactive bladder treatment), Singular (asthma treatment), Meloxicam (arthritis treatment), Bethanechol (urinary retention treatment), Famotine (antacid), Duloxetine (anti-anxiety) Sertraline (anti-depression), Lansoprazole (intestinal ulcers), Mucus Relief, Topiramate (seizure treatment) and Olopatadine (itchy eyes treatment). LPN B did not sign the medications out before administering medications to the next resident. 3. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE], with diagnoses including Cerebral Vascular Disease, Lack of Coordination, Difficulty Walking, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15 which indicated that Resident #39 was cognitively intact. Observation in Resident #39's room on 2/11/2025 at 8:15 AM, revealed Resident #39 was administered Amlodipine (high blood pressure treatment), Clopidogrel (prevent clotting), Aspirin (cerebral infarction treatment) and Labetalol (high blood pressure treatment). LPN B did not sign the medications out before administering medications to the next resident. During an interview on 2/11/2025 at 9:34 AM, the Regional Nurse Consultant confirmed that medications should be signed out after they are administered. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/12/2025 at 8:01 AM, the Director of Nursing confirmed that medications should be signed out right after they are administered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48285 Based on policy review, observation, and interview, the facility failed to ensure medications were properly and securely stored when a medication was left unattended in a resident's room for 1 of 1 sampled residents (Resident #37). The findings include: 1. Review of the facility's policy titled storage of Medications, dated 5/2015, revealed .The facility shall store all drugs and biologicals in a safe, secure and orderly manner .Drugs shall be stored in an orderly manner in cabinets, drawers, carts .or holding area to prevent possibility of mixing medications . 2. Observation in the resident's room on 2/09/2025 at 9:55 AM, revealed Resident #37 had an unsecured Heparin Flush (to maintain patency of an indwelling intravenous catheter) syringe on the over the bed table on the unoccupied side of the room that was left unattended. During an interview on 2/09/2025 at 3:02 PM, Licensed Practical Nurse (LPN) F was asked if the medication should have been left unattended at the bedside. He stated, .No, she no longer has the midline . During an interview on 2/09/2025 at 3:07 PM, Registered Nurse (RN) G confirmed that the medication should not have been left unattended at the bedside. During an interview on 2/12/2025 at 8:09 AM the Director of Nursing (DON) confirmed that medications should not be left unattended at the bedside.

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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** 46047 Based on Centers for Disease Control guidelines, policy review, record review, observation, and interview, the facility failed to ensure infection control practices to prevent the spread of infection when 1 of 4 (Licensed Practical Nurse (LPN) A) staff failed to perform hand hygiene during medication administration and when 2 of 2 (Certified Nurse Assistants (CNA) D and (CNA) E) failed to wear Personal Protective Equipment (PPE) during a transfer of a resident on Enhanced Barrier Precautions. The findings include: 1. Review of the Centers for Disease Control (CDC), Clinical Safety: Hand Hygiene for Healthcare Workers, revealed .Clinical Safety: Hand Hygiene for Healthcare Workers .CDC provides the following recommendations for hand hygiene in healthcare settings .Know when to clean your hands .Immediately after glove removal . Review of the facility's policy titled, Enhanced Barrier Precautions, dated August 2022, revealed .Enhanced barrier precautions (EBP) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .Gloves and gown are applied prior to performing the high contact resident care activities (as opposed to before entering the room) .Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include .transferring .device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator .wound care (any open skin requiring a dressing) . EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization . Review of the facility's policy titled, Handwashing/Hand Hygiene, dated October 2023, revealed .This facility considers hand the primary means to prevent the spread of healthcare-associated infections .All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, visitors .Hand hygiene is indicated .after contact with blood, body fluids, or contaminated surfaces .immediately after glove removal .The use of gloves dose not replace hand washing/hand hygiene . 2. Observation at the North Medication Cart on 2/10/2025 at 3:14 PM, revealed LPN A entered Resident #213's room and failed to perform proper hand hygiene before and after administering medications. Observation at the [NAME] Medication Cart on 2/11/2025 at 3:19 PM, revealed LPN A entered Resident #113's room and did not perform hand hygiene between donning and doffing of gloves. During an interview on 2/11/2025 at 3:38 PM LPN A was asked if she should have done hand hygiene between glove changes. LPN A stated, .yes . During an interview on 2/12/25 at 8:00 AM, the Director of Nursing (DON) confirmed the staff should perform hand hygiene between donning and doffing of gloves. 3. Review of medical record revealed Resident #113 was admitted on [DATE], with diagnoses including, Bladder-neck obstruction, Gastrostomy status, Retention of urine, and Aphasia. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #113 was moderately cognitively impaired. Review of the Physician's Order dated 2/6/2025, revealed Enhanced barrier precautions related to peg tube every shift. Review of the Physicians Order dated 2/8/2025, revealed Enhanced barrier precautions related to foley catheter. A random observation in Resident #113's on 2/11/2025 at 9: 45 AM, revealed CNA E entered Resident #113's room and failed to put on a gown and failed to perform hand hygiene before donning gloves. CNA D was observed in the resident's room holding the resident's catheter bag in her gloved hand but did not have on a gown. CNA E left the resident's room with gloved hands and entered another resident's room with the same gloves on and returned to the resident's room with a gait belt. CNA E failed to remove the gloves and perform hand hygiene before exiting the room and failed put on a gown. CNA E placed and secured the gait belt around the resident's waist. CNA D continued to hold the resident's catheter bag without a gown while CNA E and C NA D transferred the resident to another wheelchair. CNA E took the catheter bag and placed it inside a black plastic catheter bag cover and then placed it on the lower part of the resident's wheelchair. CNA D failed to remove gloves, perform hand hygiene and put on a gown before connecting the resident's peg tubing to peg site and turning on the feeding pump. CNA D exited the room and failed to remove the gloves and perform hand hygiene. CNA E failed to remove gloves and perform hand after handling the resident's catheter bag and preceded to place the resident's bed pillow on the head on the bed, and pulled the resident's bed covers from the end of bed. CNA E removed gloves, failed to perform hand hygiene before exiting the resident's room. During an interview on 2/12/2025 at 8:41 AM, the Infection Control Preventionist (ICP) confirmed staff should wear a gown and gloves when transferring a resident who is on Enhanced Barrier Precautions. The ICP confirmed staff should remove gloves and perform hand hygiene after touching potentially contaminated items. The ICP confirmed staff should not exit a resident's room with gloved hands on and enter another resident's room with same gloved hands, and staff should remove gloves and perform hand hygiene before exiting a resident's room. 48285