STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445473	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jefferson County Nursing Home	914 Industrial Park Rd Dandridge, TN 37725

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review and interview, the facility failed to resubmit a Pre-admission Screening and Resident Review (PASARR) timely after a new mental health diagnosis was added for 4 residents (Residents #3, #40, #43, and #143) of 8 residents reviewed for PASRR (PASARR). The findings include: Review of the facility's undated policy titled, PASRR POLICY, revealed .ensure that individuals with a mental disorder .receives care and services in the most integrated setting .All applicants to this facility will be screened for serious mental disorders .Any level II [2] resident who experiences a significant change in status will be screened via [by] submitting a new level I [1] PASRR . Review of Resident #3's Notice of PASRR Level I Screen Outcome dated 8/3/2023 (prior to admission to the facility), revealed .No PASRR Level II Required .DIAGNOSIS .No mental health diagnosis is known or suspected . It was noted the resident had a diagnosis of dementia/neurocognitive disorder. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis affecting Left Non-Dominant Side, Muscle Weakness, and Vascular Dementia. Review of Resident #3's medical record revealed a diagnosis of Adjustment Disorder with Mixed Anxiety and Depressed Mood was added on 11/15/2023. Review of Resident #3's comprehensive care plan initiated on 9/6/2024, revealed .RESIDENT HAS IMPULSE DISORDER . Review of Resident #3's medical record revealed a diagnosis of Impulse Disorder was added on 9/16/2024. Review of Resident #3's comprehensive care plan initiated on 2/20/2025, revealed .RESIDENT RECEIVES PSYCHOTROPIC MEDICATIONS [medications to control mental health disorders] . Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 4 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. The resident exhibited no behavioral symptoms during the 7-day lookback period. Resident #3's active diagnoses included Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Psychotic Disorder. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #3 revealed no evidence a new PASRR had been submitted when new diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood (11/15/2023) and Impulse Disorder (9/16/2024) were added. During an interview on 12/9/2025 at 2:40 PM, the Admission's Registered Nurse (RN) confirmed Resident #3's Level I PASRR dated 8/30/2023, showed no mental health diagnoses were known or suspected and confirmed a new PASRR had not been submitted for Resident #3 when new diagnoses of Adjustment Disorder with Mixed Anxiety and Depressed Mood and Impulse Disorder were added. Review of Resident #40's Notice of PASRR Level I Screen Outcome dated 1/3/2025 (prior to admission to the facility), revealed .No PASRR Level II Required .DIAGNOSIS .No mental health diagnosis is known or suspected . It was noted the resident had a diagnosis of dementia/neurocognitive disorder. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Reduced Mobility, and Dementia. Review of the medical record for Resident #40 revealed a diagnosis of Delusional Disorders was added on 1/13/2025. Review of the comprehensive care plan for Resident #40 dated 1/14/2025, revealed .uses psychotropic medications r/t [related to] Paranoia/delusions . Review of the comprehensive care plan for Resident #40 dated 1/16/2025, revealed .Periods of delusions/paranoia. Started on Zyprexa [antipsychotic medication] 1/14/2025 . Continued review revealed .Cognitive Deficits and DX [diagnosis] of Dementia . Review of the comprehensive care plan for Resident #40 dated on 1/17/2025, revealed .History of Episodes of paranoia with periods of delusions/hallucinations . Review of the medical record for Resident #40 revealed a diagnosis of Anxiety was added on 2/5/2025, and Psychosis Not Due to a Substance or Known Physiological Condition was added on 3/2/2025. Review of the comprehensive care plan for Resident #40 dated 4/22/2025, revealed .RESIDENT HAS .DEMENTIA .ANXIETY . Review of the quarterly MDS assessment dated [DATE], revealed Resident #40 scored an 8 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Resident #40 exhibited no behavioral symptoms. Resident #40's active diagnoses included Non-Alzheimer's Dementia, Anxiety Disorder, and Psychotic Disorder. Review of the quarterly MDS assessment dated [DATE], revealed Resident #40 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident #40 exhibited no behavioral symptoms. Resident #40's active diagnoses included Psychosis, Non-Alzheimer's Dementia, Anxiety Disorder, and Psychotic Disorder. Review of the medical record for Resident #40 revealed no documentation a new PASRR had been submitted to the State Designated Authority for Resident #40 after the mental health diagnoses of (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Delusional Disorder, Anxiety Disorder, and Psychosis were added to the medical record. During medical record review an interview on 12/9/2025 at 2:37 PM, the Admissions RN stated PASRRs were looked at upon admission and compared to the hospital records for diagnoses. After admission, if there are any changes in mental health diagnoses, the MDS Coordinator would be responsible to resubmit the PASRR when the quarterly MDS assessments were completed. The Admissions Nurse confirmed Resident #40's PASRR dated 1/3/2025 revealed the resident had diagnosis of dementia and no mental health diagnoses were suspected. Resident #40 had a new diagnosis of Delusional Disorder added on 1/13/2025, a new diagnosis of Anxiety added on 2/5/2025, and a new diagnosis of Psychosis added on 3/2/2025. The Admissions RN confirmed a new PASRR had not been submitted timely to include Resident #40's new diagnoses. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, and Anxiety. Review of the PASRR Notice of Exclusion from PASRR for Resident #43 dated 6/12/2023, revealed .Your neurocognitive disorder (dementia) is the primary focus of your care .If you have certain kinds of changes in your physical or mental health, you may need a new Level II evaluation .The nursing facility must submit a new Level I screening .to see if a new PASRR evaluation is needed .Anxiety Disorder (current Diagnosis) .Depression (current Diagnosis) .Does the individual have a diagnosis of dementia/neurocognitive disorder .Yes .SMI [Severe Mental Illness] is suspected .You were 'Ruled out' from further assessment through the PASRR Program .Dementia will likely be the primary focus of behavioral health treatment . Review of the medical record for Resident #43 revealed a diagnosis of Impulse Disorder was added on 6/15/2023. Review of a Physician's order for Resident #43 dated 9/29/2025, revealed .Divalproex Sodium [a medication used to treat Seizure disorder or Mood disorder] .125 MG [milligrams] .Give 1 capsule by mouth two times a day for impulse control disorder . Review of a Psychiatry Note for Resident #43 dated 10/13/2025, revealed .depakote [a medication used to treat Seizure disorder or Mood disorder] 125mg po [by mouth] BID [twice per day] .impulse control disorder . Review of Resident #43's comprehensive care plan dated 11/11/2025, revealed .RESIDENT HAS .IMPULSE DISORDER .Administer medications as ordered .RESIDENT RECEIVES PSYCHOTROPIC MEDICATIONS . Review of a quarterly MDS assessment dated [DATE], revealed Resident #43 scored an 8 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Resident #43 exhibited no behavioral symptoms. Resident #43's active diagnoses included Non-Alzheimer's Dementia, Anxiety Disorder, Depression, and Impulse Disorder. Review of the medical record for Resident #43 revealed no documentation a new PASRR had been submitted to the State Designated Authority after the diagnosis of Impulse Control Disorder was added to the medical record. Review of the Notice of PASRR Level 1 Screen Outcome for Resident #143 dated 7/28/2025 (prior to (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission to the facility), revealed PASRR Level II Onsite Evaluation required .Current diagnosis Major Depression .Rational: Your Level 1 screen shows you have evidence of serious mental illness .A level II evaluation will be initiated . Review of the PASRR Notice of Exclusion from PASRR for Resident #143 dated 8/4/2025 (prior to admission to the facility), revealed .Your neurocognitive disorder (Dementia) is the primary focus of your care . Review of the medical record revealed Resident #143 was admitted to the facility on [DATE], with diagnoses including Major Depressive Disorder with Severe Psychotic Symptoms, Dementia, Anxiety Disorder, and Parkinsons Disease. Review of the medical record for Resident #143 revealed the diagnoses of Paranoid Personality Disorder and Hoarding Disorder were added on 8/11/2025. Review of the Psychiatric Nurse Practitioner (NP) note for Resident #143 dated 8/25/2025, revealed the resident was assessed and treated for Hoarding Disorder, Anxiety, Paranoia/Delusions, Dementia, and Depression. Review of the comprehensive care plan for Resident #143 dated 8/26/2025, revealed, .resident has episodes of delusions and paranoia .resident has Depression and Anxiety with episodes of agitation and psychosis .cognitive deficits r/t Dementia . Review of the quarterly MDS assessment dated [DATE], revealed Resident #143 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Resident #143 exhibited no behaviors. Further review revealed active diagnoses included Major Depressive Disorder, Dementia, Parkinsons Disease, Anxiety Disorder, and Psychotic Disorder. Review of the medical record for Resident #143 revealed no documentation a new PASRR had been submitted to the State Designated Authority after the mental health diagnoses of Hoarding and Paranoid Personality Disorder were added to the medical record. During a medical record review and interview on 12/11/2025 at 10:55 AM, Licensed Practical Nurse (LPN) MDS Assistant reviewed the medical record and PASRR for Resident #43 and #143. The LPN MDS Assistant confirmed Resident #43 had received a new mental health diagnosis of Impulse Control Disorder on 6/15/2023. The LPN MDS Assistant confirmed the PASRR for Resident #43 dated 6/12/2023 did not include the diagnosis of Impulse Control Disorder. The LPN MDS Assistant confirmed Resident #143 had received new mental health diagnoses of Hoarding and Paranoid Personality Disorder on 8/11/2025. The LPN MDS Assistant confirmed the PASRR for Resident #143 dated 8/4/2025 did not include the diagnoses of Hoarding and Paranoid Personality Disorder. The LPN MDS Assistant further confirmed the facility failed to submit a new PASRR Level I screen when Resident #43 and #143 received new mental health diagnoses.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of medical records, and interview, the facility failed to revise the comprehensive care plan for 1 resident (Resident #117) of 29 residents reviewed for care plans. The findings include:Review of the facility's policy titled, CARE PLAN IMPLEMENTATION AND PROCESS, revised 6/4/2025, revealed .Comprehensive Care Plan .reviewed every 90 days or changes .be made as needed . Review of the medical record revealed Resident #117 was admitted to the facility on [DATE] with diagnoses including History of Falling, Cerebral Infarction, and Muscle Weakness. Review of a facility incident report for Resident #117 dated 5/17/2025, revealed .Un-witnessed Fall .Resident Description: I was trying to go to the bathroom and lost balance .reminded res [Resident] that she must use her call light and she stated she would .No injuries observed at time of incident .Ambulating without Assist .Hi [High] visibility Tape to call light . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #117 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. The resident required supervision or touching assistance from staff with toileting hygiene and transfers. The resident required partial/moderate staff assistance with personal hygiene. Review of a facility incident report for Resident #117 dated 11/2/2025, revealed .Un-witnessed Fall .Resident observed on her bathroom floor .Gait imbalance .Weakness .Ambulating without Assist .[intervention] 3 in 1 toilet [bedside toilet placed over the toilet] . Review of a comprehensive care plan for Resident #117 dated 12/9/2025, revealed .RESIDENT REQUIRES TOUCHING/ PARTIAL ASSISTANCE .1 PERSON .TRANSFERS .RESIDENT AT INCREASED RISK FOR FALLS/TRAUMA . Further review revealed the comprehensive care plan was not revised to include the high visibility tape to the call light and 3 in 1 toilet. During an observation on 12/11/2025 at 9:18 AM, revealed there was bright yellow tape to the base of Resident #117's call light. Further observation revealed a 3 in 1 toilet placed over the toilet in Resident #117's restroom. During an interview on 12/11/2025 at 9:22 AM, the Assistant Director of Nursing (ADON) stated Resident #117 had experienced a fall on 5/17/2025 and the intervention included high visibility tape to Resident #117's call light to assist in reminding Resident #117 to use her call light to alert staff for assistance with transfers. The ADON further stated Resident #117 had experienced a fall on 11/2/2025 and the intervention included for Resident #117 to receive a 3 in 1 toilet. The ADON confirmed the facility failed to revise the comprehensive care plan for Resident #117 to include the fall interventions of high visibility tape to Resident #117's call light and for Resident #117 to receive a 3 in 1 toilet.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview, the facility failed to follow a Physician's order for routine blood test for 1 resident (Resident #11) of 5 residents reviewed for routine blood test. The findings include: Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Hyperlipidemia, Bipolar Disorder, Diabetes Mellitus Type 2, and Anemia. Review of a Physician's order for Resident #11 dated 5/31/2022, revealed .Routine labs: CBC [Complete Blood Count- a blood test that measures amounts and sizes of red blood cells, hemoglobin, white blood cells and platelets], CMP [Comprehensive Metabolic Panel- a blood test that measures proteins, enzymes, electrolytes, and minerals in the body], magnesium [Magnesium level- a blood test that measures the amount of magnesium in the blood], lipid [Lipid panel- a blood test that measures the fats in the blood], vitamin D [Vitamin D level- a blood test that measures the amount of Vitamin D in the blood], ferritin [Ferritin level- a blood test that measures the amount of iron stored in the blood], TIBC [Total Iron Binding Capacity- a blood test that measures the bloods ability to attach and carry iron], folate [Folate level- a blood test that measures the amount of folate in the blood], valporic acid [Valproic Acid level- a blood test that measures the amount of the anticonvulsant drug in the blood] , Hgb A1C [Hemoglobin A1c- a blood test that measures the average blood glucose level in the blood for the past 3 months] (January and July) . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the medical record for Resident #11, revealed no results for the following blood test CBC, CMP, Magnesium level, Lipid Panel, Vitamin D level, Ferritin level, TIBC, Folate level, Valproic Acid level, or Hemoglobin A1c for January 2025 or July 2025. Review of a comprehensive care plan for Resident #11 revised 10/3/2025, revealed . Dx [diagnosis] of Hyperlipidemia .monitor labs values [blood test] as directed and notify md/np [Doctor of Medicine/ Nurse Practitioner] of results .HX [history] OF DVT's [Deep Vein Thrombosis] .Monitor laboratory values .Diagnosis of Diabetes .Schedule labs as ordered and report results . Dx of Anemia .Obtain and monitor lab/diagnostic work as ordered .resident is on diuretic therapy .Report pertinent lab results to MD .The resident uses psychotropic medications .Depakote [medication used to treat seizures and mood disorders] levels as ordered and report to MD .Monitor lab values as directed by MD/NP . During an interview on 12/11/2025 at 11:22AM, the Assistant Director of Nursing (ADON) confirmed Resident #11 had a Physician's order for the following routine blood test CBC, CMP, Magnesium level, Lipid Panel, Vitamin D level, Ferritin level, TIBC, Folate level, Valproic Acid level, and Hemoglobin A1c level to be obtained every January and July. The ADON confirmed she could not locate any results of the following blood test CBC, CMP, Magnesium level, Lipid Panel, Vitamin D Level, Ferritin level, TIBC, Folate level, Valproic Acid level, or Hemoglobin A1c for Resident #11 for the month of January 2025 or July 2025. The ADON further confirmed the facility failed to follow a Physician's order for Resident #11. During an interview on 12/11/2025 at 11:51 AM, the Nurse Practitioner stated it was his expectation for facility staff to follow all Physician's orders. The Nurse Practitioner stated he was familiar with Resident #11. The Nurse Practitioner stated in his professional opinion Resident #11 did not experience any negative outcome such as a decline in health status or hospitalization as a result of the facility not following the Physician's order to obtain routine blood test.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of medical records, observations, and interviews, the facility failed to complete dialysis communication records for 1 resident (Resident #55) of 3 residents reviewed for dialysis. The findings include: Review of the facility's undated policy titled, Hemodialysis [treatment for kidney failure] Policy and Guidelines, revealed .The licensed nurse will communicate to the dialysis facility via [by] .written format, such as a dialysis communication form . Medical record review revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease with Dependence on Renal Dialysis, Functional Quadriplegic, Obesity, and Diabetes. Review of a Physician's Progress note for Resident #55 dated 8/21/2025, revealed the resident began dialysis treatments while residing at another long term care facility and was to continue dialysis services long term. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #55 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident received dialysis services. Review of a comprehensive care plan for Resident #55 dated 8/14/2025, revealed the resident had a Dialysis Care Plan. Review of the Physician's Orders for Resident #55 dated 10/1/2025, revealed .Complete Dialysis [communication] sheet before and after dialysis . During an interview and observation on 12/8/2025 at 11:00 AM, Resident #55 stated he went to dialysis services three days a week. The resident further stated he takes a dialysis notebook with communication sheets with him when he received dialysis services. During an observation and interview on 12/9/2025 at 7:50 AM, Licensed Practical Nurse (LPN) B stated Resident #55 was scheduled for dialysis today. LPN B stated dialysis communication sheets were left in a notebook behind the nurses' desk. Residents were assessed by the nurse prior to leaving the facility for dialysis and upon return using the dialysis communication sheet. Review of the Dialysis communication sheets for Resident #55 revealed the post dialysis assessments were not completed on the dialysis communication sheets on the following dates: 11/1/2025, 11/4/2025, 11/6/2025, 11/8/2025, 11/11/2025, 11/20/2025, 11/22/2025, 11/29/2025, 12/2/2025, and 12/6/2025. During an interview on 12/11/2025 at 11:15 AM, the Director of Nursing (DON) stated it was the facility's expectation to complete the dialysis communication sheet prior to dialysis treatment and upon return to facility. The DON confirmed dialysis communication sheets for Resident #55 had not been completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, review of medical records, observation, and interview the facility failed to offer hand hygiene assistance prior to meals for 5 residents (Residents #28, #111, #162, #40, and #78) on 1 of 7 units observed for meal tray distribution.The findings include: Review of the facility's policy titled, HANDWASHING POLICY, dated 5/20/2025, revealed .Hand hygiene is any method that removes microorganisms from the hands .Upon beginning of the meal, residents .should perform hand hygiene . Review of the medical record revealed Resident #28 was admitted to the facility on [DATE] with diagnoses including Unspecified Lack of Coordination, Reduced Mobility, Need for Assistance with Personal Care, and Cognitive Communication Deficit. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #28 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was moderately cognitively impaired. Resident #28 required set up or clean-up assistance with eating and substantial/maximal assistance for personal hygiene. Review of Resident #28's comprehensive care plan revised on 9/3/2025, revealed .REQUIRES SUBSTANTIAL ASSISTANCE AND SUPERVISION WITH BATHING, GROOMING . Review of Resident #28's comprehensive care plan dated 12/4/2025, revealed .COGNITIVE DEFICITS .WITH PERIODS OF CONFUSION . During an observation on 12/8/2025 at 12:15 PM, Certified Nursing Assistant (CNA) A delivered the lunch meal tray to Resident #28. CNA A delivered the tray, donned gloves, set up Resident #28's lunch meal tray, doffed the gloves, sanitized the hands, and exited the room without offering hand hygiene assistance to Resident #28. Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dysphagia, Need for Assistance with Personal Care, and Cognitive Communication Deficit. Review of the annual MDS assessment dated [DATE], revealed Resident #111 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Resident #111 required set up or clean up assistance for eating and was dependent on staff for personal hygiene. Review of Resident #111's comprehensive care plan revised 9/8/2025, revealed .DEPENDENT ASSISTANCE AND SUPERVISION WITH BATHING, GROOMING .Provide assistance for daily care and hygiene . Review of Resident #111's comprehensive care plan revised on 12/5/2025, revealed .COGNITIVE DEFICITS . During an observation on 12/8/2025 at 12:16 PM, CNA A delivered the lunch meal tray to Resident #111. CNA A delivered the tray, donned gloves, set up Resident #111's meal tray, doffed the gloves, sanitized the hands, and exited the room without offering hand hygiene assistance to Resident #111. Review of the medical record revealed Resident #162 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Encounter for Palliative Care. Review of Resident #162's Admit/Readmit Screener dated 12/4/2025, revealed Resident #162 was oriented to person and time only. Review of Resident #162's Baseline Care Plan dated 12/4/2025, revealed .Requires 1 Person assist with all adl [Activities of Daily Living] care . Review of Resident #162's care plan dated 12/4/2025, revealed .COGNITIVE DEFICITS .NEEDS ASSISTANCE WITH DECISION MAKING .NEW admission TO FACILITY UNDER THE SERVICES OF [HOSPICE COMPANY] RESPITE . During an observation on 12/8/2025 at 12:22 PM, CNA A delivered the lunch meal tray to Resident #162. CNA A delivered the tray, donned gloves, set up Resident #162's tray, doffed the gloves, sanitized the hands, and exited the room without offering hand hygiene assistance to Resident #162. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Need for Assistance with Personal Care, and Delusional Disorders. Review of Resident #40's comprehensive care plan revised on 7/14/2025, revealed .episodes of paranoia with periods of delusions/hallucinations . Review of Resident #40's comprehensive care plan revised on 10/10/2025, revealed .Provide assistance for daily care and hygiene . Review of the quarterly MDS assessment dated [DATE], revealed Resident #40 scored a 3 on the BIMS assessment which indicated the (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident had severe cognitive impairment. Resident #40 required setup or clean-up assistance for eating and was dependent on staff for personal hygiene. During an observation on 12/8/2025 at 12:24 PM, CNA A delivered the lunch meal tray to Resident #40. CNA A delivered the meal tray, donned gloves, set up Resident #40's tray, doffed the gloves, sanitized the hands, and exited the room without offering hand hygiene assistance to Resident #40. Review of the medical record revealed Resident #78 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Need for Assistance with Personal Care, and Cognitive Communication Deficit. Review of Resident #78's comprehensive care plan revised on 10/22/2025, revealed .Provide assistance for daily care and hygiene . Review of the quarterly MDS assessment dated [DATE], revealed Resident #78 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Resident #78 required setup or clean-up assistance for eating and was dependent on staff for personal hygiene. Review of Resident #78's comprehensive care plan dated 10/23/2025, revealed .COGNITIVE DEFICITS . During an observation on 12/8/2025 at 12:26 PM, CNA A delivered the lunch meal tray to Resident #78. CNA A donned gloves, set up the tray, doffed the gloves, sanitized the hands, and exited the room without offering hand hygiene assistance to Resident #78. During an interview on 12/8/2025 at 12:35 PM, CNA A stated residents were to be offered hand hygiene assistance prior to meals with a sanitizing wipe or hand sanitizer. CNA A confirmed she had not offered hand hygiene assistance prior to meals for Residents #28, #111, #162, #40, and #78. During an interview on 12/8/2025 at 12:44 PM, the Director of Nursing (DON) confirmed staff were to offer hand hygiene assistance to all residents prior to meals with hand sanitizer, sanitizing wipes, or offer assistance to wash hands with soap and water.