STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445477	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dickson Health and Rehab	901 N Charlotte Dickson, TN 37055

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to provide care to ensure that acceptable parameters of nutritional status were maintained and dietary recommendations were reviewed and implemented for 3 of 3 (Resident #2, #6, #7) residents reviewed for weight loss. The findings include: 1. Review of the undated facility policy titled, Weight Monitoring, revealed .Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.The physician should be informed of a significant change in weight and may order nutritional interventions.The Registered Dietician or Dietary Manager should be consulted to assist with interventions; actions are recorded in the nutrition progress notes. 2. Review of the medical record revealed Resident #2 was re-admitted to the facility on [DATE] with diagnoses including Diabetes (DM), Dementia, Malnutrition, Nausea with Vomiting, Dysphagia, Gastro-Esophageal Reflux Disease (GERD), Anxiety, and Adult Failure to Thrive. Review of the revised Care Plan dated 2/24/2026, revealed .Focus.[Resident #2] is at risk for impaired nutrition/weight r/t [related to] vitamin deficiencies, abnormal low BMI [body mass index], anemia, GERD, HLD [hyperlipidemia-high levels of fat in the blood], hx [history] of significant weight changes.Interventions.Monitor/record/ report to MD [Medical Doctor]. significant weight loss: 3lbs [pounds] in 1 week, >[greater than] 5% [percent] in 1 month, >7.5% in 3 months, >10% in 6 months.RD to evaluate and make recommendations PRN [as needed].Focus.resists her meals at times r/t to dementia, constipation, and vomiting.at risk for possible fluid balance flucation [fluctuation]/dehydration r/t Nausea, Vomiting.Has Magic Cup [a supplement option for adding nutrition, calories, and protein for those experiencing involuntary weight loss] in the evenings to support calorie intake.Interventions.RD to evaluate and make recommendations PRN.Weigh monthly and PRN 2/9/2023. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 6 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was severely cognitively impaired. Resident #2 was noted for weight loss, not on a prescribed weight-loss regimen, and required staff setup with eating. Review of the Physician Order dated 1/27/2026, revealed Regular diet, Regular Texture .Thin consistency. Review of the Physician Order dated 1/27/2026, revealed Dietary supplements may be used when determined appropriate by IDT [Interdisciplinary Team] or RD [Registered Dietician]. Initiate specific order for resident. Review of the Physician Order dated 1/29/2026, revealed House Supplement Shake 4oz [ounces] two times a day Give 120mL [milliliters] orally twice per day with lunch and dinner . Review of the Nutrition: Dietary Complete Quarterly Manager Quarterly/Annual review dated 3/5/2026, revealed weight stable last 2 weeks, resident has a history of weight loss .4 oz [ounces] House Supplement .Rd recommended fortified potatoes @ [at] lunch & frozen nutritional treat @ supper. Staff offers snacks between meals & with food related activities . Review of the progress note dated 4/25/2026, revealed Note Text: RD Note.med pass 120 cc [cubic centimeter] BID [twice a day] started (1/26), increased Med pass TID [three times a day] recommended (4/22). Diet: Regular .Rsd [Resident] requests (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mushroom or chicken noodle soup w [with]/crackers to supper tray daily (does not always like what is served).Recommendations.d/c [discontinue] Med pass [a fortified nutritional supplement] 120 cc BID and start sugar-free Med pass 120 cc TID.Consider an appetite stimulant .Obtain weekly weights . There was no documentation the facility conducted a follow up on the dietary recommendation to increase the Med Pass to 120 cc to TID, obtain an order for the use of an appetite stimulate, or to perform weekly weights for Resident #2. Review of the progress note dated 5/6/2026, revealed Note Text.Current interventions include Thrive [dietary supplement], fortified potatoes at lunch, Thrive and soup at supper, and House supplement 4 oz BID. Visited Resident this AM [morning]; good intake of breakfast. Food preferences reviewed and updated.Recommendations .Add fortified potatoes at supper and provide gravy at lunch and dinner to enhance intake.Increase Med Pass to TID for additional caloric/protein support.Continue weekly weights for closer monitoring .Consider appetite stimulant as medically appropriate.Resident remains at high nutritional risk due to significant weight loss and underweight status. Will continue to monitor PO intake, weight trends, and response to interventions closely . There was no documentation the facility conducted a follow up on the dietary recommendation to increase the Med Pass to 120 cc to TID, the use of an appetite stimulate, or to perform weekly weights for Resident #2. During an interview on 5/27/2026 at 11:34 AM, the Interim DON was asked who receives the RD recommendations. The Interim DON stated, She sends them to us, they usually go to [Unit Manager]. The Interim DON was asked if the dietary recommendations should have been addressed or followed. The Interim DON stated, They should have and I've got to find out why they were not.We have weekly meetings with [the RD]. The Interim DON was asked if weight loss could potentially put a resident's health at risk. The Interim DON stated, It could. During an interview on 5/28/2026 at 10:52 AM, Physician F was asked how she is made aware of recommendations. Physician F stated, I talk to the DON and nurse managers about who needs to be seen and why. Physician F was asked if she had been made aware of the dietary recommendations made related to Resident #2's weight loss on 4/25/2026 and 5/6/2026. Physician F stated, I was made aware of them yesterday, I think the weight seemed to be better, we were going to keep her med pass at bid, her blood sugar is a concern. I talked to the DON yesterday, I will see her at bedside to follow, I didn't want to start something at this time. During an interview on 5/28/2026 at 11:32 AM, The Unit Manager was asked if she was made aware of the RD recommendations for Resident #2 on 4/25/2026 and 5/6/2026. The Unit Manager stated, I did receive those, I believe the Interim DON was tagged on those emails. The Unit Manager was asked who is responsible to make sure the Physician is made aware of the RD recommendations. The Unit Manager stated, Whoever received the email with the recommendation. During an interview on 5/28/2026 at 3:20 PM, the Medical Director was asked if he was made aware of the dietary recommendations related to weight loss for Resident #2 on 4/25/2026 and 5/6/2026. The Medical Director stated, Not directly .I don't recall noticing any weight loss or orders. The Medical Director was asked if he should have been made aware of recommendations regarding the resident's weight change. The Medical Director stated, Yes. The facility failed to notify the physician of RD recommendations for nutritional intentions on a resident with altered nutritional status and increased risk for weight loss. 3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Dementia, Anorexia, Moderate Protein-Calorie Malnutrition (body's inability to absorb nutrients resulting in inadequate nutrition) , Depression, Dehydration, Gastroesophageal Reflux Disease, Diabetes Mellitus, and Hypomagnesemia. Review of the Physician order dated 2/3/2026, revealed .dietary supplements may be used when determined appropriate by IDT [Interdisciplinary Team] or RD. Initiate specific order for resident. Review of the comprehensive Care Plan dated 2/4/2026, revealed .[Named Resident #6] .at risk for possible fluid balance fluctuation/ dehydration r/t [related to] Poor intake .is at risk for altered nutritional/hydration status r/t Alzheimer's, Dementia, appetite stimulant .will maintain nutritional status and body weight through the review date with no significant changes .Administer medications as ordered. Monitor for side effects and effectiveness .Encourage (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consumption of fluids provided .Monitor weights weekly r/t weight loss .Monitor/document/report to nurse/dietitian and MD PRN for difficulty swallowing, holding food in mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, pocketing food in mouth .Registered Dietitian [RD] to evaluate and make recommendations PRN .Weigh a minimum of monthly, as ordered, and PRN . Review of the admission MDS assessment dated [DATE], revealed Resident #6 scored 00 on the BIMS assessment, which indicated she was severely cognitively impaired. Resident #6 had a weight loss of 5 percent (%) or more in the last month or loss of 10% or more in last 6 months and complained of difficulty or pain with swallowing. Review of the Physician order dated 2/13/2026, revealed .magic cup or equivalent with lunch meal one time a day for supplement. Review of the Physician order dated 3/22/2026, revealed .resident receives the anti-depressant: REMERON The behavior associated with their depression is noted to be: INSOMNIA, DECREASED APPETITE. Review of the Physician order dated 4/30/2026, revealed .Regular diet, Finger Foods texture, Thin consistency Diet. Review of Nutrition Note dated 5/20/2026 at 12:03 PM revealed . A nutritional assessment was completed on this date for [Named Resident #6]. Resident with a history of weight changes. Resident's current diet order is therapeutically regular. Diet texture is regular. Resident's meal intakes are fair averaging 51-75%. Finger foods provided food preferences provided B: pancakes L: magic cup, fruit and dessert D: magic cup, fruit and dessert Per ADL documentation, resident is independent with eating. Per ADL documentation, resident requires set-up or clean-up with eating. Resident eats meals in dining room. Noted Remeron order, which may help stimulate appetite. Trialed Mighty Shake [nutritional, protein-rich shakes designed to add extra calories and essential nutrients to a person's diet] today; resident accepted and appeared to enjoy supplement. Recommend sending Mighty Shake with lunch daily to provide an additional 200 kcal and 6 g protein to support nutritional intake . There was no documentation the facility conducted a follow up on the dietary recommendation to send Might Shakes with Resident #6's lunch. During an Interview on 5/27/2026 at 3:27 PM, The RD was asked how often are you at the facility. RD stated, . at facility every Wednesday.I send recommendations every Wednesday.before I leave, I send RD recommendations and weekly weights .to Administrator, HR, DON, Unit Manager. The RD was asked if staff notified her of physicians' responses to her recommendations. The RD stated, .I don't know. The RD was asked if she was able to enter orders on the computer. RD stated, .I do not enter any orders in computer, I give recommendation, order entry is up to the provider. The RD was asked if she had weight loss meetings. The RD stated, .Weight loss meeting have been on Wednesday's at 1PM. The RD was asked who attended weight loss meeting. The RD stated, .MDS, Unit Manager, not sure who else is there.In meeting the recommendations can be taken care of then and there. The RD was asked if as RD she made recommendations should she be notified of the outcome of her recommendations. RD stated, .It would be nice in a perfect world.I'm hired to give a recommendation. The RD acknowledged she had made recommendations for Resident #6. The RD was asked if she was aware of any of her recommendations being implemented. The RD, stated .I'm not sure. During interview on 5/28/2026 at 9:22 AM, the Interim DON was asked if the facility has weekly IDT meeting. The Interim DON stated, .Yes. The Interim DON was asked if weight loss was discussed in these meetings. The Interim DON stated, .Yes, we talk with the RD and she gives recommendation.I was unaware that the recommendations were not being followed through on.I spoke with the RD and she showed me her documentation of recommendations and the RD is now going to make sure the kitchen manager, and myself have the information. During a phone interview on 5/28/2026 at 10:59 AM, Physician F was asked when she was made aware of the RD's recommendations for Resident #6. Physician F stated, .Yesterday was the first that I had heard about any recommendations from the RD .We use a different computer system and it is hard to find the RD's notes.In the future we will need to find a new way of relaying information. During phone interview on 5/28/2026 at 4:00 PM, the Medical Director was asked if he was familiar with Resident #6. The Medical Director stated .Yes .The Medical Director was asked if he was aware of the recommendations by RD. The MD stated .I didn't get the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendations .RD recommendations should be put in computer and then I can sign off on them . There is an order in the computer dated 2/3/2026 that states: .Dietary supplements may be used when determined appropriate by IDT or RD. Initiate specific order for resident . The facility failed to notify the Physician of RD recommendations for nutritional intentions on a resident with altered nutritional status and increased risk for weight loss. 4. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Depression, Diverticulitis, and Edema. Review of the MDS assessment dated [DATE], revealed Resident #7 scored a 3 on the BIMS assessment, which indicated she was severely cognitively impaired. Resident #7 required setup or clean-up assistance from staff for eating and weight loss of 5% (precent), or more in the last month or loss of 10% or more in last 6 months, not on a physician prescribed weight loss program. Review of the Registered Dietician's Nutrition Note, dated 4/25/2026 at 19:18 [7:18 PM], revealed .Wt is up after significant loss +3.0% change over 30 days . Regular diet, Regular texture, ThinL [thin liquids], with poor intake .with many meal refusals.Will monitor weekly weights, restart Med pass [a fortified nutritional supplement], 120cc TID [three times per day], consider appetite stimulant for poor PO [by mouth] intake . There was no documentation the facility conducted a follow up on the dietary recommendation to start Med Pass supplements or an appetite stimulant. Review of the Care Plan revised care plan dated 5/2/2026, revealed, .at risk for altered nutritional / hydration status r/t increased confusion at times and history of diverticulosis.Honor food preferences and update.Monitor and record meal intakes.Offer snacks between meals and PRN .RD to evaluate and make recommendations PRN. Review of the quarterly MDS assessment dated [DATE], revealed Resident #7 scored a 5 on the BIMS assessment, which indicated she was severely cognitively impaired. Resident #7 required set up for eating and had a not prescribed weight loss of 5% (precent) or more in the last month or loss of 10% or more in last 6 months. Review of the Physician's Order Summary Report for May 2026 revealed there were no orders for Med Pass or an appetite stimulant. Review of the signed Physician's Order dated 5/27/2026, revealed Dietary supplements may be used when determined appropriate by IDT or RD. Initiate specific order for resident. Review of the signed Physician's Order dated 5/27/2026 , revealed Add supplement: Supplement Shake 4 oz [ounces] between meals and bedtime There was no documentation the facility conducted a follow up on the dietary recommendation to start Med Pass supplements or an appetite stimulant until 5/27/2026. During an interview on 5/27/2026 at 3:09 PM with the Interim Director of Nursing (DON), the Interim DON was asked if an order was needed for Med Pass. The Interim DON stated, .Yes. The Interim DON was asked if the recommendation for med pass, 120 cc, three times a day was started. The Interim DON stated, Resident #7 has an order dated 11/8/2025 for mighty shake [a nutritional supplement], 4oz [ounces] between meals and at bedtime. I do not see where the Med Pass was started . The Interim DON was asked if the provider was notified of the RD's recommendation for the 120 cc of Med Pass three times a day and to consider an appetite stimulant. The Interim DON stated, .I do not see where the provider was notified. The Interim DON was asked what she expected staff to do when the facility gets a recommendation from the RD. The Interim DON stated, .They will have to speak to the provider to get their verification and document what the provider said. If the provider agrees, the order should be transcribed. If the provider disagrees, they still need to document the rationale and notify the RD so that we will be on the same page. During an interview on 5/27/2026 at 3:37 PM, the RD was asked how she knew the recommendations were reviewed, the provider was notified, and orders were put in. The RD stated, I email the recommendations, weekly, to everyone. The RD was asked to explain everyone. The RD stated, The [named Administrator] [named staff] who is Human Resource, [Named Staff], I do not know her title, and [named, Certified Dietary Manager] and [named Unit Manager]. The RD was asked did she attend the weight loss meetings. The RD stated, I attend every Wednesday. The RD was asked if her recommendations and the response by the provider are discussed in the weight loss meetings. The RD stated, I do not know. The RD was asked did she expect to be notified of the providers response after the recommendations (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for 120 cc of med pass three times per day and appetite stimulant for [Resident #7]. The RD stated, My recommendations is what I was hired for. During an interview on 5/27/2026 at 4:48 PM, the Administrator (ADM) was asked whenever a recommendation was given by the RD what he expected staff to do. The ADM stated, .The recommendation goes to nursing, and the nurse will process the recommendation and will follow through with the recommendation with the NP [Nurse Practitioner] or physician. The nurse staff will talk through with IDT [Interdisciplinary Team-a professionals from two or more disciplines who actively collaborate, share decision-making, and coordinate their efforts]. If they have questions, the nurses will talk to the physician, or the RD can follow through with the NP or the physician regarding the recommendation. The ADM was asked how he would know if the RD's recommendations were addressed and followed up on. The ADM stated, .The recommendation should come up in clinical meetings . meetings are Monday through Friday. The ADM was asked who attended the clinical meetings. The ADM stated, .The attendees of the daily clinical meeting are the IDT team, which is Nursing, MDS [Minimum Data Set] Coordinator, Social Service, Dietary Manager, and Activities During an interview on 5/28/2026 at 11:40 AM, the Unit Manager was asked who was responsible for following up with the physician to ensure the physician received the RD recommendations. The Unit Manager stated, I would be the person. The Unit Manager was asked did she review the RD recommendations for Resident #7. The Unit Manager stated, I was working the cart that week. During an interview on 5/28/2026 at 12:10 PM, the Unit Manager was asked did she notify the provider of the RD's recommendations for 120 cc of med pass three times a day and to consider an appetite stimulant for Resident #7. The Unit Manager stated, No. During an interview on 5/28/2026 at 4:07 PM, the Medical Director was asked the process when recommendations come in from the RD. The Medical Director stated, The recommendation come in as an order, and I sign off on the RD recommendations.the recommendation [related to Resident #7] was not in the orders for me to review. The facility failed to notify the Physician of RD recommendations for nutritional intentions on a resident with altered nutritional status and increased risk for weight loss. During an interview on 5/27/2026 at 10:57 AM, the RD was asked to describe some interventions that may be used for residents. The RD stated, I go see them, I look at medication, diagnoses, fluid, look at the chart, look at resident, look at teeth, appetite, talk with them, observe a lunch or breakfast, talk with them, food first . add a fortified food, or preference, supplements med pass, mighty shakes, magic cup, for an appetite stimulate. I can make a recommendation for that or Vitamin D. The RD was asked who she makes aware of recommendations. The RD stated I put the copy of recommendations on [Unit Manager] desk, I email [the Administrator], [Social Services Director], [Unit Manager], [Interim Director of Nursing [DON], and [Dietary Manager]. The RD was asked who she would address the continued weight loss with. The RD stated, I would go to [the Administrator] or [Unit Manager]. I can do dietary changes too . The RD then stated, I am doing my part, it's not my job to babysit, I come every Wednesday, I am available, I meet with everyone. The RD was asked if she had addressed with anyone that her recommendations are not being followed. The RD stated, I'm not going to say anything. The RD was asked if a resident received her recommendations, could it make a difference regarding weight loss. The RD stated, Yes, I think it could. During an interview on 5/28/2026 at 12:45 PM the Unit Manager was asked who attends the weight loss meetings. The Unit Manager stated, .the Interim DON/MDS coordinator, Social Worker, Activities Director, Director of Therapy and RD who is only here on Wednesdays.RD is new to this facility .the previous RD would make recommendations directly to the MD and then place the order in computer .We thought the new RD was following this same process but have found out that she was not. RD is a contracted employee. The Unit Manager was asked if she followed up with the RD regarding the recommendations. The Unit Manager stated, .did not follow up to see if recommendation were implemented. The Unit Manager was asked how she was made aware of RD's recommendations. The Unit Manager stated, .I was made aware of recommendation through an email from RD .If it was a recommendation and approved by MD then it could be put in computer, RD was responsible for notifying MD of recommendation.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to follow Physician's orders for 5 of 7 (Resident #8, #13, #15, #17 and #60) residents and the facility failed to have orders for oxygen administration and tracheostomy care for 2 of 7 (Resident #62 and #70) reviewed for respiratory care. The findings include: 1. Review of the undated facility policy titled, Oxygen Administration, revealed .Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.Oxygen is administered under orders of a physician.Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. Review of the undated facility policy titled, Medication Administration, revealed .Medications are administered by licensed nurses, or staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice .Review MAR [Medication Administration Record] to identify medication to be administered . Review of the undated facility policy titled, Tracheostomy Care, revealed .facility will ensure that residents who need respiratory care .is provided such care consistent with professional standards of practice, the comprehensive person-centered care plan and resident goals and preferences .tracheostomy care will be provided according to physician's orders, comprehensive assessment and individualized care plan such as monitoring for resident specific risks for possible complications .General considerations include .provide tracheostomy care per physician order .maintain a suction machine, a supply of suction catheters, correctly sized cannulas, and an ambu bag [single patient use manual resuscitator] easily accessible for immediate emergency care . 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory Failure and Dependence on Supplemental Oxygen. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was severely cognitively impaired. She was receiving Oxygen Therapy. Review of the Physician's Orders dated 5/7/2026, revealed .2L BNC [Binasal Cannula- a tubing used to deliver oxygen through the nose] to keep oxygen saturation above 90% every shift for Hypoxia . Further review of the Physician Orders dated 5/7/2026 revealed, Change out O2 [Oxygen] nasal cannula [tube that delivers oxygen through the nose] one time a day every Sun [Sunday]. Review of the Treatment Administration Record (TAR) dated 5/1/2026 - 5/31/2026 revealed, Change out O2 nasal cannula one time a day every Sun had not been completed on 5/24/2026. During an observation in Resident #8's room on 5/26/2026 at 10:20 AM, 1:04 PM, and 4:15 PM revealed the nasal cannula was dated 5/11/2026. The facility failed to follow Physician's Orders when the nasal cannula was not changed on 5/17/2026 or 5/24/2026. 3. Review of the medical record revealed Resident #13 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Respiratory Failure, and Dependence on Supplemental Oxygen. Review of the annual MDS assessment dated [DATE], revealed Resident #13 scored a 9 on the BIMS assessment, which indicated she was moderately cognitively impaired. She was receiving Oxygen Therapy. Review of the Physician's Orders dated 7/7/2025, revealed .2L BNC [Binasal Cannula- a tubing used to deliver oxygen through the nose] to keep oxygen saturation above 90% every shift for Hypoxia . Review of the Physician's Order dated 7/7/2025 revealed, Change oxygen tubing one time daily every Sun. Review of the TAR dated 5/1/2026 - 5/31/2027 revealed, Change oxygen tubing one time daily every Sun had not been completed on 5/24/2026. During an observation in Resident #13's room on 5/26/2026 at 10:42 AM, 1:06 PM and 4:17 PM revealed oxygen tubing dated 5/17/2026. The facility failed to follow Physician's Orders when the oxygen tubing was not changed on 5/24/2026. 4. Review of the medical record revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Dependence on (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Supplemental Oxygen. Review of the significant change MDS assessment dated [DATE], revealed Resident #15 scored an 11 on the BIMS assessment, which indicated she was moderately cognitively impaired. She was receiving Oxygen Therapy. Review of the Physician's Orders dated 5/7/2026, revealed .2L BNC [Binasal Cannula- a tubing used to deliver oxygen through the nose] to keep oxygen saturation above 90% every shift for Hypoxia . Review of the Physician's Orders dated 5/7/2026 revealed, Change out O2 nasal cannula one time a day every Sun. Review of the TAR dated 5/1/2026 - 5/31/2026 revealed, Change out O2 nasal cannula one a day every Sun was not signed out as completed on 5/24/2026. During an observation in Resident #15's room on 5/26/2026 at 10:16 AM, 1:16 PM, and 4:18 PM revealed the nasal cannula was dated 5/7/2026. The facility failed to follow Physician's Orders when the nasal cannula was not changed on 5/10/2026, 5/17/2026 and 5/24/2026. 5. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Dependence on Supplemental Oxygen. Review of the annual MDS assessment dated [DATE], revealed Resident #17 scored a 6 on the BIMS assessment, which indicated he was severely cognitively impaired. He was receiving Oxygen Therapy. Review of the Physician's Orders dated 5/7/2026, revealed .2L BNC [Binasal Cannula- a tubing used to deliver oxygen through the nose] to keep oxygen saturation above 90% every shift for Hypoxia . Review of the Physician's Orders dated 5/7/2026 revealed, Change out O2 nasal cannula one time a day every Sun. Review of the TAR dated 5/1/2026 - 5/31/20206 revealed, Change out O2 nasal cannula one time a day every Sun was signed not signed out as completed on 5/24/2026. During an observation in Resident #17's room on 5/26/2026 at 10:13 AM, 1:16 PM, and 4:18 PM revealed nasal cannula dated 5/17/2026. The facility failed to follow Physician's Orders when the nasal cannula was not changed on 5/24/2026. 6. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE], with diagnoses including Left Tibia Fracture, Chronic Obstructive Pulmonary Disease, Diabetes, Anemia and Seizures. Review of the quarterly MDS assessment dated [DATE], revealed Resident #60 scored a 15 on the BIMS assessment, which indicated she was cognitively intact. Review of the Physician's Orders dated 5/6/2026, revealed .2L BNC to keep oxygen saturation above 90% every shift for Hypoxia . Review of the Physician's Orders dated 5/10/2026, revealed Change out 02 nasal cannula one time a day every Sun. Review of the TAR dated 5/2026, revealed staff failed to change and document the change out of O2 nasal cannula tubing on 5/24/2026. Observation in Resident #60's room on 5/26/2026 at 9:53 AM,11:54 AM, 4:05 PM, revealed resident lying in bed with O2 tubing dated 5/17/26 (5/17/2026). Observation in Resident #60's room on 5/27/2026 at 7:44 AM, revealed resident lying in bed appears to be sleeping, O2 tubing dated 5/17/26 (5/17/2026). The facility failed to follow Physician's Orders to change the oxygen tubing every Sunday (weekly). During an interview on 5/27/2026 at 11:03 AM, the Interim DON was asked how often should oxygen tubing be changed. The Interim DON stated, I would have to say that we would follow the physician orders or the facility policy. The Interim DON was asked should there be an order for the tubing to be changed. The Interim DON stated, Yes. The Interim DON was asked if she would expect oxygen tubing to have dates on them. The Interim DON stated, We usually just sign them out. During an interview on 5/27/2026 at 11:30 AM, the Unit Manager was asked if there is an order to change the nasal cannula weekly on Sunday, if it was expected that the nasal cannula would be changed every Sunday. The Unit Manager stated, Yes. 7. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Pharynx, Acquired Absence of Larynx, Diabetes, and Dependence on Supplemental Oxygen. Review of the admission note dated 3/30/2026, revealed .Resident admitted to facility from home due to needing house renovations to be completed .Resident has a Trach [Tracheostomy] 6.5 .order for 10L [liters] O2 . Review of the comprehensive care plan dated 4/1/2026, revealed .presence of a tracheostomy .will have no abnormal drainage around trach site through the review date .Ensure that trach ties are secured at all times .Give humidified oxygen as prescribed .Monitor the resident for complications such as unexplained removal (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445477	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dickson Health and Rehab	901 N Charlotte Dickson, TN 37055

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of the tracheostomy, aspiration and the potential for respiratory infection .and airway complications such as tracheal infections, mucous plugging, tracheal erosion and stenosis .Monitor/document respiratory rate, depth and quality . Review of the admission MDS assessment dated [DATE], revealed Resident #62 had a BIMS score a 13, which indicated Resident #62 was cognitively intact. Tracheostomy care and oxygen therapy were not noted on the assessment. Review of the Physician's Order dated 5/7/2026, revealed .Trach: aerosol collar [used to deliver oxygen and moisture] with oxygen at 10 liters two times a day . Review of the Physician's Orders revealed there were no physician orders to provide care of Resident #62's tracheostomy until 5/27/2026. During an interview on 5/28/2026 at 9:22 AM, the Interim DON was asked if she was aware there were no trach care orders in the computer for Resident #62 from admission until 5/27/2026. The Interim DON stated .I was not aware there were no orders .as soon as I found that out, orders were put into the computer.this is something that slipped through the cracks, but I am working to make sure it doesn't happen again. During a phone interview on 5/28/2026 at 4:03 PM, the facility Medical Director was asked if Resident #62, who was admitted on [DATE], should have had tracheostomy care orders placed on admission. The Medical Director stated . Yes, I will take the blame for this . The Medical Director stated .Yes, she was on respite care, that turned into long term care .I signed off on orders that were entered 5/27/2026, for trach care .I take full responsibility .I should have put in orders for trach care on admission . 8. Review of the medical record revealed Resident #70 was admitted to the facility on [DATE], with diagnoses of Chronic Obstructive Pulmonary Disorder (COPD), Heart Failure, Chronic Respiratory Failure, Dependence on Supplemental Oxygen, Panic Disorder, and Depression. Review of the facility's Standing Physician Orders (dated 2/1/2026) were scanned into the resident's medical record after admission but were never entered onto the Medication Administration Record (MAR). The ordered revealed, .SHORTNESS OF BREATH .Elevate HOB [Head of Bed] 30-45 degrees every shift unless contraindicated .SHORTNESS OF BREATH .O2 [Oxygen], 2L Nasal Cannula, for O2 Sats 88% or less as needed for Hypoxia [insufficient oxygen supply in blood] or respiratory distress obtain O2 Sats .For reading of 88% start O2 at 2L/min nc [nasal cannula]. Notify MD [Medical Director] within 1 hour of starting O2 . An MDS assessment was not available due to the admission date of 5/19/2026, assessment was not completed, transmitted and accepted. Review of the progress note dated 5/19/2026, revealed .O2 via [by way of] nasal cannula at 4 liters to keep sats [saturation of oxygen in blood] above 90% . Review of the baseline care plan dated 5/20/2026, revealed no documentation of oxygen use. Review of the Physician's Orders dated May 2026 revealed there were no active orders for continuous oxygen administration for Resident #70. Review of MAR dated 5/19/2026 to 5/27/2026, revealed there were no orders for oxygen administration. Review of the admission progress note dated 5/21/2026, revealed .Patient has a diagnosis of COPD. She has O2 at 2L [liters]/min [minute] via nasal cannula . Review of the progress note dated 5/22/2026, revealed .Patient has a diagnosis of COPD. She has O2 at 2L/min via nasal cannula . Review of the progress note dated 5/23/2026, revealed .Patient has a diagnosis of COPD. She has O2 at 2L/min via nasal cannula . Review of the progress note dated 5/24/2026, revealed .Patient has a diagnosis of COPD. She has O2 at 2L/min via nasal cannula . Review of the progress note dated 5/25/2026, revealed .Patient has a diagnosis of COPD. She has O2 at 2L/min via nasal cannula . During an observation in Resident #70's room on 5/26/2026 at 9:40 AM, Resident #70 was sitting up in a wheelchair wearing a nasal canula connected to an oxygen tank on the back of the chair. The oxygen tank was set to 3L/min. During an observation in the dining room at 5/26/2026 at 11:58 AM, Resident #70 was sitting in wheelchair wearing a nasal canula connected to an oxygen tank set on 3L/min. During an observation in Resident #70's room on 5/26/2026 at 3:03 PM, Resident #70 lying in bed, wearing a nasal cannula connected to an oxygen concentrator set on 3 L/min. During an observation in Resident #70's room on 5/27/2026 at 9:23 AM, Resident #70 resident sitting up in bed wearing a nasal cannula connected to an oxygen concentrator set on 2.5 L/min. During an interview on 5/27/2026 at 10:20 AM, LPN C was asked if she could look in Resident #70's orders and tell me what (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445477	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the order was for oxygen administration. LPN C stated, I do not see an order in her chart, I will look at her hospital paperwork. There is an order for Oxygen on 3L in her hospital chart I will put that order in. LPN C was then asked who was responsible for entering orders for oxygen administration on admission. LPN C stated, Usually, those orders just populate but since we have a new system, it may not have transferred over. The provider also comes in within 2 days and adjusts or puts any new orders in. LPN C was then asked if she or any of the other nurses are currently assessing the resident on her oxygen administration. LPN C stated, Yes. LPN C was then asked where those assessments are being documented. LPN C stated, If the nurses are documenting it may be in the skilled nurses note. During an interview on 5/27/2026 at 11:03 AM, the Interim DON was asked if there should be an order in a resident's chart if the resident is being administered oxygen. The Interim DON state, Absolutely. The Interim DON was asked if oxygen administration should be signed on the MAR when being administered. The Interim DON stated, Yes. The Interim DON was asked how you can be sure a resident is receiving the correct oxygen administration rate if there is not an order. The Interim DON stated, We can't assume the correct administration rate. We would have to call and get an order. The Interim DON was asked who was responsible for putting these orders in on admission when a resident is receiving continuous oxygen. The Interim DON stated, The Unit Manager puts them in, if it's on day shift and she is present, and the receiving nurse checks behind to verify orders are correct. If on night shift and the Unit Manager is not available, the receiving nurse puts the orders in, and the Unit Manager checks behind that nurse to make sure they are correct. If it is a weekend, we have a weekend RN [Registered Nurse] manager that puts them in and then they are verified by the receiving nurse. The Interim DON was asked would you expect your nurses to check orders to make sure the resident is receiving correct administration of oxygen. The Interim DON stated, Absolutely.

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	445477	A. Building B. Wing	05/28/2026

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on policy review, employee time sheet review, and interview, the facility failed to ensure a Registered Nurse (RN) was on duty for at least 8 consecutive hours a day, 7 days a week, for 11 of 31 days reviewed and failed to ensure the facility had an RN that was not the Director of Nursing (DON) when the census was above 60 for 7 of 31 days reviewed. The findings include: 1. Review of the facility policy titled, Nursing Services-Registered Nurse (RN), dated 10/2017, revealed .It is the intent of the facility to comply with Registered Nurse staffing requirements.utilize the services of a Registered Nurse for at least 8 consecutive hours per day, 7 days a week.The Director of Nursing may serve as a charge nurse only when the facility has average daily occupancy of 60 or fewer residents. 2. Review of the employee time clock sheets dated 4/25/2026 through 5/24/2026, revealed there was no RN on duty for 8 consecutive hours on the following dates: a. 5/2/2026 b. 5/3/2026 c. 5/7/2026 d. 5/8/2026 e. 5/9/2026 f. 5/10/2026 g. 5/15/2026 h. 5/16/2026 i. 5/17/2026 j. 5/18/2026 k. 5/19/2026 The facility was unable to provide additional employee time sheets for the above dates as requested. 3. Review of the employee time clock sheets dated 11/30/2025, revealed the DON was the only RN on duty in the facility on that date. 4. Review of the employee time clock sheets dated 4/25/2026 through 5/24/2026, revealed the DON was the only RN on duty in the facility for the following dates: a. 5/7/2026 b. 5/13/2026 c. 5/14/2026 d. 5/19/2026 e. 5/20/2026 f. 5/21/2026 5. During an interview on 5/28/2026 at 10:30 AM, the DON confirmed there should be an RN on duty for 8 consecutive hours, 7 days a week. The DON was shown the time sheets and was asked if she covered any days as the only RN on duty. The DON stated, .Yes.I have.I understand that the census will affect whether I can be the only RN in the building for staffing.We just hired another full time RN.she has agreed to help if it doesn't look like they are going to be fully covered.

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	445477	A. Building B. Wing	05/28/2026

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on policyˆreview and interview the facilityˆfailed toˆensure employment of a qualified Infection Preventionist toˆmonitorˆand maintain the facility's Infection Prevention and Control Program.ˆˆThis had the potential to affected 65 of 65 residentsˆresidingˆin the facility.ˆ The findings include: Review of the facility policy titled, Infection Preventionist, dated 2/1/2026, revealed .The facility will employ one or more qualified individuals with responsibility for implementing the facility's infection prevention and control program.whose primary role is to coordinate and be actively accountable for the facilities infection prevention and control program to include the antibiotic stewardship program.The IP [Infection Preventionist] will physically work on site in the facility.The IP must have obtained specialized IPC [Infection Control and Prevention] training beyond initial professional training or education prior to assuming the role and must provide evidence of training through a certification(s) of completion.ˆˆ The facility failed to ensure there was an IP at the facility to implement the facility's infection prevention and control program. During an interview on 5/27/2026 at 8:02 AM, in the Administrator's office, the Administrator (ADM) was asked who the IP was. The ADM stated, We do not have an IP, the Unit Manager has been doing the IP duties. The ADM was asked if the Unit Manager had an IP certification. The ADM stated, No. During an interview on 5/28/2026 at 9:20 AM, in the Administrator's office, the ADM was asked about not having a certified IP at the facility. The ADM stated, There was a Director of Nursing (DON) who was the IP. She was certified, her last day of work was 3/24/2026, and there has not been a certified IP at the facility since 3/24/2026. The ADM was asked if he was aware of any plans for getting a certified IP. The Administrator stated, They are wanting to get people certified.want it to be a Registered Nurse . The ADM was asked should the facility have an onsite certified infection preventionist. The ADM stated, Yes, per requirements.

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	445477	A. Building B. Wing	05/28/2026

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Dickson Health and Rehab	901 N Charlotte Dickson, TN 37055

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 2 of 5 (Licensed Practical Nurse (LPN) A and LPN B) nurses left 2 of 6 (North Hall medication cart and North Hall treatment cart) medication storage areas unsecured and unattended. The findings include: 1. Review of the undated facility policy titled, Medication Storage, revealed .All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.Only authorized personnel will have access to the keys to locked compartments.During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.Narcotics and Controlled Substances.Schedule II drugs and back-up stock of Schedule III, IV and V medications are stored under double-lock and key.Schedule II controlled medications are to be stored within a separately locked permanently affixed compartment when other medications are stored in the same area, such as in refrigerator. Review of the undated facility policy titled, Controlled Substance Administration and Accountability, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances.Controlled substances are stored in a separate compartment of an automated dispensing system or other locked storage unit with access limited to approved personnel.Areas without automated dispensing systems utilize a substantially-constructed storage unit with two locks. 2. During an observation and interview at the North Hall Nurse's station on 5/27/2026 at 10:00 AM, the North Hall Medication cart was noted to be unlocked and unattended. LPN B was noted to be sitting behind the nursing desk, out of sight of the medication cart. LPN B was asked should their medication cart be locked when out of view. LPN B stated, It's not locked? Yes, it should be. During an interview on 5/27/2026 at 10:04 AM, the Interim Director of Nursing (DON) was asked if she would expect the medication carts to be locked if unattended. The Interim DON stated, Absolutely, yes. 3. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE], with diagnoses including Cerebral Palsy, Moderate Protein-Calorie Malnutrition, and Pressure Ulcer of Right Buttock, Stage 4.ˆ Review of the Physician Order dated 1/28/2026, revealed .Cleanse RIGHT buttock with Dakin [an antiseptic] solution, pat dry, apply collagen [a protein used in wound care to promote tissue repair] powder, alginate with silver [used to provide absorption and antimicrobial properties in a single dressing] and cover with dry dressing once daily and prn [as needed] . ˆReview of the care plan dated 3/23/2026 revealed [Resident #32] is at risk for impaired skin integrity and pressure ulcer development r/t (related to) incontinence and impaired mobility.has (continued on next page)

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	445477	A. Building B. Wing	05/28/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury to right buttock. Review of the Significant Change Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not completed. Resident #32 was noted for severely impaired cognitive skills for daily decision making, dependent of staff for eating, toileting, bed mobility, and transfer, always incontinent of urinary and bowel, noted for 1 stage 4 pressure ulcer, and hospice care. During an observation and interview at the North Hall Nurse's station on 5/27/2026 at 4:21 PM, revealed LPN A approached the North Hall Treatment Cart that was stored behind the Nurse's desk unattended and unlocked. LPN A removed a package of collagen powder wound filler, a package of calcium alginate with silver, a bottle of Dankin solution, gauze, and a 4x5 inch bordered gauze dressing to perform wound care for Resident #32. LPN A was asked if the treatment cart was locked. LPN A stated .I don't think so. LPN A was asked if it should have been locked. LPN A stated Yes. ^ During an interview on 5/28/2026 at 9:50 AM, the DON was asked if medication carts should be locked when unattended. The DON stated Yes, locked at all times. The DON was asked if that included treatment carts. The DON stated, We lock those as well. ^

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	445477	A. Building B. Wing	05/28/2026

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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 policy review, medical record review, observation, and interview, the facility failed to maintain and ensure the prevention and spread of infection when 1of 1 (Licensed Practical Nurse (LPN) A) nurses failed to perform hand hygiene between glove changes for 1 of 2 (Resident #32) sampled for wound care and when 1 of 3 (LPN B) nurses failed to wear Personal Protective Equipment (PPE) during enteral medication administration for 1 of 1 (Resident #62) sampled resident observed for medication administration by way of (via) percutaneous endoscopic gastrostomy (PEG) tube The findings include: 1. Review of the undated facility policy titled, Enhanced Barrier Precautions (EBP) revealed .To implement enhanced barriers precautions for the prevention of transmission of multidrug-resistant organisms .All staff receive training on enhanced barrier precautions upon hire and at least annually.An order for EBP will be obtained for residents with any of the following: wounds.feeding tubes.indwelling medical devices. 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy, Moderate Protein-Calorie Malnutrition, and Pressure Ulcer of Right Buttock, Stage 4. Review of the Physician Order dated 1/28/2026, revealed .Cleanse RIGHT buttock with Dakin [an antiseptic] solution, pat dry, apply collagen [a protein used to promote wound healing] powder, alginate with silver [used to provide absorption and antimicrobial properties in a single dressing] and cover with dry dressing once daily and prn [as needed] . Review of the care plan dated 3/23/2026 revealed .[Resident #32] is at risk for impaired skin integrity and pressure ulcer development r/t [related to] incontinence and impaired mobility.has pressure injury to right buttock. Review of the Significant Change Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) assessment was not completed, Resident #32 was noted for severely impaired cognitive skills for daily decision making, dependent of staff for eating, toileting, bed mobility, and transfer, always incontinent of urinary and bowel, noted for 1 stage 4 pressure ulcer, and hospice care. Observation in Resident #32's room on 5/27/2026 at 4:17 PM, LPN A donned a gown and surgical mask, knocked on the door, sanitized hands and donned gloves. Registered Nurse (RN) D was in the room, with gown, gloves and mask on. RN D assisted positioning Resident #32 onto her right side during wound care. No dressing noted to wound area related to it had come off. LPN A cleaned the wound bed using gauze and Dakins, removed gloves, gloves and gauze placed in red bag, donned clean gloves without performing hand hygiene, area pat dry using gauze, removed gloves, donned clean gloves without performing hand hygiene, collagen powder and silver alginate applied to wound bed, bordered gauze applied. LPN A removed gloves and donned clean gloves without performing hand hygiene to assist with turning the resident. LPN A then removed the gloves, gown, and mask. LPN A sanitized hands. During an interview on 5/27/2026 at 4:42 PM, LPN A was asked when hand hygiene should be (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445477	A. Building B. Wing	05/28/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performed. LPN A stated, Every time you come in and out of a patient's room, if you used the restroom, and anytime you touch anything contaminated. LPN A was asked if hand hygiene should be performed between all glove changes. LPN A stated Yes. LPN A was asked if she had performed hand hygiene between all glove changes during wound care. LPN A stated No. During an interview on 5/28/2026 at 9:50 AM, the Director of Nursing (DON) was asked when staff should perform hand hygiene. The DON stated, Before going into a room and when coming out as well, after brief changes, and before serving food and medicine. The DON was asked if staff should perform hand hygiene between gloves changes. The DON stated, They should. The DON was asked if not performing appropriate hand hygiene could create the risk of contamination or infection. The DON stated, It can. 3. Review of the medical record revealed Resident #62 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of Pharynx, Acquired Absence of Larynx, Diabetes, and Dependence on Supplemental Oxygen. Review of the Physician Order revealed no orders for Enhanced Barrier Precautions. Review of the Physician Order dated 3/31/2026, revealed LORazepam Oral Tablet 1 MG [milligram] (Lorazepam) .Give 1 mg .every 6 hours as needed for Generalized anxiety . During an observation in Resident #62's room on 5/27/2026 at 10:48 AM, LPN B performed hand hygiene, pulled medication from narcotic drawer, signed out the medication, put the medication in a pill pouch, crushed the medication and placed the medication in medication cup. LPN B pulled 6 syringes of 10cc (cubic centimeters) water, knocked on door and let resident know who she was and purpose of visit, donned gloves, and verified g-tube (tubing used for supplemental feedings) placement via auscultation. LPN B placed syringes on barrier on the over bed table, then flushed g-tube with 30 ccs water prior to giving medications, administered Lorazepam 1mg mixed with water, flushed with 30 ccs. ^All medications flowed via gravity without issue. LPN B placed syringe in plastic bag and placed on bedside table. LPN B removed gloves then washed hands with soap and water. LPN B failed to wear proper PPE during medication administration. During an interview on 5/27/2026 at 11:34 AM, LPN B was asked if she should have worn isolation gown while administering medications to resident who was in EBP. LPN B replied, Oh my gosh, Yes I guess I should have. During an interview on 5/27/2026 at 11:52 AM, the Interim DON was asked would you expect your nurses to wear an isolation gown while administering medications to a resident that is in EBP. The DON stated, Yes, I would.