| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 445482 | A. Building<br>B. Wing | 09/11/2025 |

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| The Village at Germantown | 7930 Walking Horse Circle<br>Germantown, TN 38138 |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Centers for Disease Control and Prevention (CDC) guidelines, facility policy review, Glucometer (a device used to check blood sugar levels with the use of a blood sample) User's Guide review, skills check off list review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when a multi-use blood glucose meter was not cleaned or disinfected with an Environmental Protection Agency (EPA) approved disinfecting wipe to prevent the cross-contamination of bloodborne pathogens and failed to ensure staff properly performed hand hygiene for 1 of 2 (Resident #23) sampled residents reviewed for blood glucose monitoring. On 9/9/2025, 2 of 3 (Licensed Practical Nurse (LPN) A and Registered Nurse (RN) B) nurses failed to properly clean and disinfect the multi-use blood glucose meter before and after use on Resident #23 in accordance with current infection control recommendations and facility policy and Registered Nurse (RN) B failed to properly perform hand hygiene when performing a blood glucose test and administering insulin. The facility's failure to ensure staff properly disinfected the blood glucose meter that was used for multiple residents, in accordance with recommendations and the facility's policy, placed the residents at risk for potential contamination with bloodborne pathogens and had the likelihood to cause serious injury, harm, impairment, and/or death, which resulted in Immediate Jeopardy. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to appropriately clean and disinfect a multi-use blood glucose meter during medication administration for Resident #23.^^ The Administrator and the Administrator for Memory Care Assisted Living were verbally informed of the Immediate Jeopardy on 9/9/2025 at 9:26 PM, in the Administrator's office.^ The Administrator and Director of Nursing (DON) were given the IJ template on 9/10/2025 at 9:10 AM, in the Private Dining Room. The facility was cited Immediate Jeopardy at F-880 at a scope and severity of J.^^ An extended survey was conducted and completed on 9/11/2025. An acceptable Removal Plan, which removed the immediacy of the jeopardy was received on 9/10/2025 at 9:12 AM, and was validated onsite by the surveyors on 9/11/2025 through review of in-services and posttests, audits, and staff interviews.^ The Immediate Jeopardy for F-880 began on 9/9/2025 and continued through 9/11/2025. The Immediate Jeopardy was removed on 9/12/2025. The facility's non-compliance at F-880 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.^ The findings include: 1. Review of the CDC Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/2024, revealed .Clean and disinfect blood glucose meters after every use, per the manufacturer's instructions .These recommendations apply in .Long-term care settings .Blood glucose meters can easily become contaminated during use. When used in healthcare or other group settings, germs and infections can spread if preventive measures are not in place .If healthcare providers use blood glucose testing or insulin administration devices on more than one patient, equipment and supplies may become contaminated. Unsafe practices during assisted monitoring of blood glucose and insulin administration contribute to the spread of hepatitis B virus [HBV-a serious liver infection most commonly spread by<br>(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 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | exposure to infected body fluids], hepatitis C virus [HCV-an infection caused by a virus that attacks the liver and is spread by contact with contaminated blood], HIV [Human Immunodeficiency Virus-an immune system disease that interferes with the body's ability to fight infection and disease], and other infections. Unsafe practices include .Using a blood glucose meter for more than one person without cleaning and disinfecting it in between uses .Failing to change gloves and perform hand hygiene between fingerstick procedures . 2. Review of the facility's policy titled, Glucometer Disinfection, dated 12/19/2024, revealed .The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis B virus.Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. Review of the facility undated policy titled, Hand Hygiene, revealed .All staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors.'Hand Hygiene' is a general term for cleaning your hands by hand washing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub.Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to the attached hand hygiene table.After handling contaminated objects. Before applying and removing personal protective equipment (PPE) including gloves.Before preparing resident care products.After handling items potentially contaminated with blood, body fluids, secretions, or excretions . Review of the facility's policy titled, Blood Glucose Monitoring, dated 12/19/2024, revealed .The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. 3. Review of the (Named Glucometer) User Instruction Manual dated 4/2021, revealed .Cleaning and Disinfecting.The meter should be cleaned and disinfected after use of each patient. This Blood Glucose Monitoring System may only be used for testing multiple patients when Standard Precautions and the manufacturer's disinfection procedures are followed.We have validated [Named] Healthcare Bleach Germicidal Wipes.CaviWipes1, and .[Named] Germicidal Disposable Wipe for disinfecting the [Named Glucometer] multi meter. 4. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE], with diagnoses including Dementia, Congestive Heart Disease, Diabetes, and Chronic Pulmonary Edema. Review of the Physician's Order for Resident #23 dated 8/22/2025, revealed .Insulin lispro [medication used to treat diabetes] (u [units]-100) 100 unit/ml [milliliter] subcutaneous solution [generic] - 100 unit/ml Subcutaneous [sq] Four times daily < [less than] 70 Hypoglycemic Protocol 70-149 Hold 150 thru 199 give 2.0 Units 200 thru 249 give 3.0 Units 250 thru 299 give 4.0 Units 300 thru 349 give 5.0 Units > [greater than] 349 6 units. Review of the Care Plan for dated 8/25/2025, revealed .DIABETES-[Named Resident #23] has alteration in Metabolic Function related to Diabetes. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 2, which indicated Resident #23 had severe cognitive impairment. Active diagnoses included Type 2 Diabetes Mellitus. Review of the Medication Administration Record (MAR) dated 9/2025, revealed Resident #23 received insulin before meals and at bedtime and blood glucose levels were scheduled to be checked at 7:30 AM, 12:30 PM, 5:00 PM, and 9:00 PM on the day of the surveyor's onsite survey. Observation at the Care Base 3 Medication Cart on 9/9/2025 beginning at 12:15 PM, revealed LPN A removed the blood glucometer from the black carry case in the top drawer, gathered the glucometer and supplies, and walked down the hall to Resident #23's room. Then LPN A placed the glucometer on a barrier on the nightstand, washed her hands, and donned clean gloves. LPN A retrieved an alcohol prep pad and cleaned the glucometer with the alcohol pad. Then LPN A placed the glucometer on the barrier on the nightstand and left the room to retrieve Resident #23 from the dining room. LPN A returned to the room with Resident #23 and washed her hands, donned a clean pair of gloves, and performed the blood glucose test. LPN A then gathered the trash and threw it in the trash can, removed the gloves, and washed her hands. LPN A donned a clean pair of gloves and used an alcohol prep pad to clean the glucometer. LPN A placed the (continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | glucometer on the nightstand to air dry while she retrieved Resident #23 from the dining room. LPN A went to the Care Base 3 Medication Cart and retrieved the insulin pen and supplies for Resident #23 and reentered the Resident's room. LPN A washed her hands, donned a clean pair of gloves and administered the insulin. Then she removed the gloves, washed her hands, and returned Resident #23 to the dining room. LPN A went back to the Resident's room, washed her hands, gathered the glucometer and Insulin pen, and returned to the Care Base 3 Medication Cart. LPN A placed the blood glucometer in a black carry case and placed the case in the drawer of the medication cart without cleaning or disinfecting the glucometer. Observation and interview at the Care Base 3 medication cart beginning on 9/9/2025 at 4:45 PM, revealed RN B opened the medication cart and removed a black carry case that contained a glucometer, testing strips, lancets (medical device used to make a tiny prick or puncture in the skin to collect a small blood sample), and alcohol pads. RN B removed the testing strip container and read the expiration date. RN B failed to perform hand hygiene before gathering the supplies for a blood glucose check. RN B left the medication cart with supplies in her hand. RN B returned to the medication cart at 5:06 PM, placed the black case with the glucometer and testing supplies in it on the medication cart. RN B opened the medication cart and removed a cleaning wipe from the purple top (Named) Wipe container and wiped off a white plastic tray. RN B gathered the black carry case, tray, and a pair of gloves and entered Resident #23's room. RN B placed the items on the tray and placed the tray on Resident #23's nightstand, washed her hands and donned gloves. RN B used an alcohol wipe to clean glucometer. RN B was then asked what the process is for cleaning the glucometer. RN B stated, Clean with an alcohol pad before and purple wipes after and allow time to dry before putting up. RN B was asked how do know the nurse before cleaned the glucometer. RN B stated, When the glucometer is in the pouch [black carry case] and the pouch [black carry case] is zipped up. RN B checked the Resident's blood glucose and with gloved hands exited the Resident's room with the supplies. RN B failed to remove her gloves and failed to preform hand hygiene before exiting Resident #23's room. RN B walked with gloved hands to the Care Base 3 medication cart, placed the testing strip and lancet in the sharps (disposable container for needles, syringes, lancets, razors, and sharp objects) container, and removed her gloves. RN B failed to perform hand hygiene after she removed her gloves at the medication cart. RN B opened the medication cart, got a (Named) Germicidal Wipe, cleaned the glucometer, and placed the glucometer on a barrier. RN B gathered Resident #23's insulin Lispro pen and supplies from the medication cart, reviewed the Resident's order, and turned the dial to 4 units. RN B failed to perform hand hygiene before gathering the Resident's medication. RN B entered Resident #23's room and donned gloves. RN B failed to perform hand hygiene before putting on gloves. RN B removed the cap from the insulin pen and failed to wipe the tip of the insulin pen with an alcohol pad before she attached the needle to the insulin pen. RN B administered Resident #23's insulin and wheeled Resident #23 to the dining room with gloved hands. RN B failed to remove gloves and perform hand hygiene after administering the insulin and before exiting the Resident's room. RN B walked to the medication cart, removed the needle from the insulin pen, placed it in the sharps container, and removed the gloves. RN B failed to perform hand hygiene after she removed the gloves. RN B opened the medication cart, placed the insulin pen in the medication cart, and placed the glucometer back in the black carry case. RN B failed to properly clean and disinfect the glucometer prior to use and failed to properly perform hand hygiene. During an interview on 9/11/2025 at 1:26 PM, the Director of Nursing (DON) stated, No, I was not aware that the nurses were using alcohol pads to clean the glucometers. The DON was asked would she say there was a system failure with cleaning glucometers. The DON stated, Yes, with two nurses, it was. During an interview on 9/11/2025 at 1:56 PM, the Administrator was asked what steps did you follow after we presented the IJ. The Administrator stated, .On Wednesday [9/10/2025] morning the DON and I talked about it, talked with the staff, and reviewed the policies and manufacturer guidelines. We determined nurses did not use [the] appropriate cleaning process for [the] glucometer. The Administrator was asked if this was a system failure. The Administrator<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | stated, Yes, absolutely. Allegation of compliance 9/11/2025 On 9/10/25, when facility was notified of Immediate Jeopardy for F880, the Director of Nursing and [NAME] President of Healthcare reviewed the policy for glucometer disinfection and cross-reference with the manufacture's guidelines for needed revision. Policy revised to follow manufacture's guidelines. The Medical Director was notified on 09/10/2025 by the [NAME] President of Healthcare. On 9/10/25 the Director of Nursing and [NAME] President of Healthcare reeducated LPN A and RN B on the protocol of proper glucometer disinfection. Beginning 9/10/25 and ending 9/11/25 the DON and Nurse Supervisor conducted a Mandatory in-service with all LPN and RN staff at the beginning of the day shift and will continue until all staff have completed in-service. Any staff missing in-services will not work until they have received training. Following the in-service, a post test will be conducted with all employees. Those in services are one on one with Director of Nursing or RN Supervisor and signed by participants. On 9/10/25 an audit was conducted by DON to ensure wipes presaturated with an EPA registered healthcare disinfectant were stocked on each med cart. On 9/10/25 the Blood Glucose Competency form was placed on med cart for reference. Beginning 9/10/25 an audit of each med cart to ensure they are stocked with wipes presaturated with an EPA registered healthcare disinfectant will be conducted daily for four weeks by the RN Supervisor. Beginning 9/10/25 Competencies of glucometer disinfection will be conducted weekly for four weeks by the DON or Supervisor. Competency will be validated by a passing score of 100%. Signed by (Named the [NAME] President of Healthcare for the facility.) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to ensure residents were free from unnecessary medications for 3 of 5 (Resident #2, #5, and #9) reviewed for unnecessary medications. The findings include: 1. Review of the facility policy titled, Use of Psychotropic Medications(s), dated 12/19/2023, revealed .Residents who receive an antipsychotic medication will have an Abnormal Involuntary Movement Scale (AIMS) test performed on admission, quarterly, with a significant change in condition, change in antipsychotic medication, PRN [as needed] or as per facility policy.The effects of the psychotropic medications on a residents physical, mental, and psychosocial well-being will be evaluated on an ongoing basis such as.In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturer's specifications, and the resident's comprehensive plan of care.The resident's response to the medications(s) including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record. 2. Review of the medical record review revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Metabolic Encephalopathy, Dementia, Hypertension, Insomnia, Anxiety, and Depression. Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview Mental Status (BIMS) score of 2, which indicated Resident #2 was severely cognitively impaired, with active diagnoses of Anxiety, Depression, Non-Alzheimer's Dementia, and the use of antipsychotic, antidepressant, and antianxiety medications. Review of the Physician's Orders dated 8/30/2025, revealed .Ativan [medication to treat anxiety] 1mg [milligram] .3 times daily for Anxiety . Review of the Physician's Orders dated 8/26/2025, revealed . Olanzapine [an antipsychotic medication] 5mg .at bedtime . Review of the August 2025 Medication Administration Record (MAR) revealed the facility failed to assess and document side effects and behavior monitoring for the use of an antianxiety and an antipsychotic medication. Review of the September 2025 MAR revealed the facility failed to assess and document side effects and behavior monitoring for the use of an antianxiety and an antipsychotic medication. The facility was unable to provide documentation that an AIMS test was completed for Resident #2 upon admission to the facility on 8/26/2025. During an interview on 9/11/2025 at 11:47 AM, the Director of Nursing (DON) was asked when should an AIMS test be completed. The DON stated, On admission, quarterly, and with a significant change . The DON was asked did the facility complete an AIMS when Resident #2 was admitted on [DATE]. The DON stated, No, but we should have . The DON was asked should the facility have completed behavior and side effects monitoring for Resident #2 for the use of an antipsychotic, antianxiety, and an antidepressant medication. The DON stated, Yes. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Insomnia and Bipolar Disorder. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, indicated Resident #5 had intact cognition and the resident received antianxiety, antipsychotic, and antidepressant medications. Review of the Physician's Order dated 8/19/2025, revealed .Buspirone [antianxiety medication] 5 mg .at bedtime . Review of the Physician Order dated 8/19/2025, revealed .Latuda [an antipsychotic, used to treat depressive episodes] .40 mg daily . Review of the Physician's Order dated 8/19/2025, revealed .Citalopram [an antidepressant] 20 mg .daily . Review of the August 2025 MAR revealed the facility failed to monitor the side effects of psychotropic medications for Resident #5. Review of the September 2025 MAR revealed the facility failed to monitor the side effects of psychotropic medications for Resident #5. The facility was unable to provide side effect monitoring for Resident #5. 4. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, and Anxiety. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 5, which indicated Resident #9 was severely cognitively impaired and received antianxiety and antidepressants medications. Review of the Physician's Order<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | dated 7/15/2025, revealed .Buspirone 5 mg .5:00 PM . Review of the Physician's Order dated 7/15/2025, revealed Zoloft [an antidepressant] 100 mg .bedtime . Review of the August 2025 MAR revealed the facility failed to monitor the side effects of psychotropic medications for Resident #9. Review of the September 2025 MAR revealed the facility failed to monitor the side effects of psychotropic medications for Resident #9. The facility was unable to provide side effect monitoring for Resident #9. During an interview on 9/11/2025 at 10:28 AM, the DON was asked should there be side effect monitoring for the use of Antianxiety, Antidepressants, and Antipsychotic medications on the August 2025 MAR and the September 2025 MAR for Resident #5 and Resident #9. The DON stated, .Yes .should be monitored every shift .someone failed to put the order in . |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on policy review, observation, and interview, the facility failed to ensure food was stored, handle, prepared, and served under sanitary conditions, when food was found opened and undated, and dirty cooking utensils were found on the floor. The census was 52 with 49 residents receiving a meal tray from the kitchen. The findings include: 1. Review of the facility policy titled, Food Storage, dated 1/14/2024, revealed .Date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk foods.Each item is clearly labeled and dated before being refrigerated. Review of the facility undated policy titled, Cleaning Dishes/Dish Machine, revealed .All flatware, serving dishes, and cookware will be washed, rinsed, and sanitized after each use. Observation and interview during the initial tour in the kitchen on 9/8/2025 at 9:15 AM, revealed the Certified Assistant Dining Director confirmed that open food items should be labeled and dated when the following items were observed in the reach-in freezer: 1 open and undated box of salted butter chips 1 open and undated 12 ounce (oz) bottle of water 1 open and undated box of assorted popsicles Observation during the initial tour in Care Base 1 Rehab dining room on 9/8/2025 at 9:37 AM, revealed the following in the reach-in cooler: 1 open and undated 32-oz carton of ocean spray 100 precent (%) pineapple1 open and undated 46-oz carton of thick and easy clear hydrolyte thickened water with a mint of lemon 1 open and undated 46-oz carton of thickened iced tea 1 open and undated 56-oz bottle of orange juice 1 open and undated 46-oz carton of (Named Brand) 100% grape juice 1 open and undated 46-oz carton of cranberry juice cocktail During the initial tour in Care Base 3 Long Term Care (LTC) dining room on 9/8/2025 at 9:52 AM, revealed the following in the reach-in cooler: 1 open and undated 46-ounce carton of cranberry juice cocktail1 open and undated 56-ounce plastic bottle of orange juice 1 open and undated 32-ounce carton of scrambled egg mix liquid Observation in the ice cream freezer on 9/8/2025 at 5:15 PM, revealed the following: one 3-gallon container of open and undated vanilla bean ice cream Observation in the kitchen on 9/9/2025 at 10:50 AM, revealed the following 2 large cooking pots with red sauce substance inside the covering1 colander on the floor 3 large3 large (Named) containers on the floor 1 open and undated 5-pound bag of breaded okra 1 open and undated 16-ounce container of ground cayenne pepper 1 open and undated 7-ounce container of thyme leaves 1 open and undated 15-ounce container of ground cloves 1 open and undated 4-ounce container of whole tarragon During an interview on 9/10/2025 at 5:06 PM, the Certified Assistant Dining Director was asked should dirty cooking dishes be on the floor. The Certified Dietary Manager stated, .No, they should not have been on the floor. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**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 the environment was free from accident hazards when unsecure sharps were observed in 4 of 56 (Residents #2, #12, #29, and #42) sampled residents' rooms. The findings include: 1. Review of the facility policy titled, Sharps Disposal, dated 1/2001, revealed .The facility shall discard contaminated sharps into designated containers.Whoever uses contaminated sharps will discard them immediately or as soon as feasible into designated containers.Contaminated sharps will be discarded into container that are .Closable, Puncture resistant, Leakproof on sides and bottom, Labeled or color-coded in accordance with our established labeling system. 2. Review of the Medical Record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, Falls, Anxiety, and Depression. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 2, which indicated Resident #2 was severely cognitively impaired. Resident #2 required assistance with Activities of Daily Living skills (ADLs). Observations in the Resident's room on 9/8/2025 at 9:30 AM, revealed an open package of 5 disposable razors on the Resident #2's bathroom sink. Observation and interview in Resident #2's room on 9/8/2025 at 9:45 AM, revealed Licensed Practical Nurse (LPN) D was asked should razors be left unattended and unsecured in the resident's room. LPN D stated razors should be stored in the storage room and disposed of in the sharps container once they have been used. 3. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Repeated Falls, Parkinson's Disease, Muscle Weakness, and Assistance with Personal Care. Review of the admission MDS dated [DATE], revealed a BIMS score of 13, indicating Resident #12 was cognitively intact. Resident #12 required set-up assistance of staff with personal hygiene. Observations in the Resident's room on 9/8/2025 at 9:45 AM revealed an open package of 5 disposable razors on Resident #12's bathroom sink. Observation and interview in Resident #12's room on 9/8/2025 at 9:50 AM, revealed LPN D was asked should razors be left unattended and unsecured in the resident's room. LPN D stated razors should be stored in the storage room and disposed of in the sharps container once they have been used. 4. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Pulmonary Edema, Anxiety, Kidney Disease, Pacemaker, and Heart Failure. Review of the admission MDS dated [DATE], revealed a BIMS score of 15, indicating Resident #29 was cognitively intact. Resident #29 required set-up assistance of staff with personal hygiene. Observation in Resident #29's room on 9/8/2025 at 9:25 AM revealed an open package of 8 disposable razors on Resident #29's bathroom sink. Observation and interview in Resident #29's room on 9/8/2025 at 9:30 AM, revealed LPN D was asked should razors be left unattended and unsecured in the resident's room. LPN D stated razors should be stored in the storage room and disposed of in the sharps container once they have been used. 5. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE], with diagnoses including Anxiety, Depression, Dementia, Hypertension, and Kidney Failure. Review of the admission MDS revealed the MDS was incomplete due to resident admitting on 9/3/2025 and it was not yet due to be completed. Observation in Resident #42's bathroom on 9/8/2025 at 9:12 AM, revealed an open package of 4 razors on the counter, 1 razor on the counter, and 1 razor in the wash basin on the bathroom counter. Observation and interview in Resident #42's bathroom on 9/8/2025 at 9:30 AM, revealed LPN D was asked should razors be left unattended and unsecured in the resident's room. LPN D stated razors should be stored in the storage room and disposed of in the sharps container once they have been used. During an interview on 9/10/2025 at 3:02 PM, the Director of Nursing (DON) was asked if razors should be left unattended in the resident's bathrooms. The DON stated that razors should be stored in the storage room and not be left in<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445482 | A. Building<br>B. Wing | 09/11/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Village at Germantown | 7930 Walking Horse Circle<br>Germantown, TN 38138 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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|---|---|
| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident's rooms unattended and if they have been used, they should be disposed of in the biohazard sharps container after use. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation, and interview, the facility failed to ensure medications were properly stored and secured for 2 of 5 (Resident #5 and #23) residents observed when 2 of 5 (License Practical Nurse (LPN) A and LPN C) staff members left a medication unattended and out of sight during medication pass and a random observation. The findings include: 1. Review of the facility's policy titled, Medication Storage, dated 12/19/2023, revealed .It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms .sufficient to ensure proper sanitation, temperature .and security .During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart .^^ Review of the facility policy titled, Nebulizer Therapy, dated 12/19/2023, revealed .It is the policy of this facility for nebulizers treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions.observe resident during the procedure for any change in condition . 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Dyspnea, and History of Pulmonary Embolism. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #5 had intact cognition. Review of the Physician Order dated 9/2/2025, revealed .Ipratropium-albuterol [breathing treatment in the form of a fine mist, used to improve breathing] 0.5 mg [milligram]-3 mg/(per)3 mL [milliliters] .Nebulizer Solution Inhalation .four times a day . Observation in Resident's #5 room on 9/8/2025 at 4:33 PM, revealed Resident #5 in the room, the nebulizer machine (used to turn liquid medication into a fine mist) turned on and a mask on Resident #5's face. There was no nurse at the bedside while Resident #5 received the breathing treatment. During an interview on 9/8/2025 at 4:35, LPN C confirmed she should not have left the resident alone while the resident received the breathing treatment. During an interview on 9/11/2025 at 11:44 AM, the Director of Nursing (DON) confirmed the nurse should stay in the room the entire time while the resident is receiving the breathing treatment to make sure the resident is tolerating the treatment. 3. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including Dementia, Congestive Heart Disease, Diabetes, and Chronic Pulmonary Edema. Review of the Physician Order dated 8/22/2025,^revealed .Insulin Lispro [medication used to decrease blood sugar levels] .100 unit/ml . four times per day . The insulin dosage was based on the results of the resident's blood sugar and a sliding scale (range of results). If the blood glucose results were less than 70 refer to the Hypoglycemic Protocol, if 70-149 hold the insulin, if 150 thru 199 give 2 units, if 200 thru 249 give 3 units, if 250 thru 299 give 4 units, if 300 thru 349 give 5 units, and if greater than 349 give 6 units. Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 2, which indicated Resident #48 had severe cognitive impairment. The resident had a diagnosis Type 2 Diabetes Mellitus. Observation and interview at the Care Base 3 medication cart on 9/9/2025 beginning at 12:15 PM, revealed LPN A removed the glucometer from the top drawer, gathered the blood glucose meter and supplies, and walked down the hall to Resident #23's room. LPN A left Resident #23's room to retrieve the Resident from the dining room and assisted him to his room. She went to the Care Base 3 medication cart gathered the insulin pen and supplies. LPN A went back to the Resident's room and administered the insulin. LPN A laid the insulin pen on the barrier next to the glucometer in the Resident's room and left the room to assist Resident #23 back to the dining room. LPN A left the insulin pen out of sight and unattended when she went down the hallway to the dining room. During an interview on 9/10/2025 at 4:55 PM, the DON was asked should the nurses leave medications out of sight and unattended. The DON stated, No, Ma'am. |