STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445495	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Collierville Nursing and Rehabilitation, LLC	490 West Poplar Avenue Collierville, TN 38017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on facility policy review, observation, and interview, the facility failed to maintain a clean and sanitary environment in the kitchen when food debris was noted on top of and inside the deep fryer, the floor around the stove, and deep fryer, crumbs and debris in the silverware tray and on metal food prep tables, the deep fryer had oil drippings down its front casing, oil and debris build up and was dripping oil onto the floor, there was a greasy substance on the metal shield between the grill and the deep fryer, the floor was slippery, the wall behind the two-compartment sink and the viewing glass around the steam table had splatter marks, 2 metal prep carts with thick greasy buildup and food debris, and storage bins had food debris and a sticky substance, unsanitary handling of food and food equipment at the steamtable, and when staff was unable to accurately test the chemical level in the 3-compartment sink. The facility's census was 83 and 79 residents received food trays from the kitchen.ˆ The findings include: 1. Review of the facility policy titled, Environment, dated 10/2019, revealed .It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary environment.Dining Service Director will insure [ensure] that the physical plant is maintained in a clean and sanitary manner, including floors, walls.will insure [ensure] that all employees are knowledgeable in the proper procedures for cleaning all food services equipment and surfaces. 2. Review of the facility policy titled Food: Preparation, dated 10/2019, revealed .Dining Services Director or Cook(s) are responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.is responsible to ensure that all.food contact equipment are cleaned and sanitized after every use . 3. Observations in the kitchen on 6/8/2026 at 9:30 AM, and 6/9/2026 at 2:15 PM, revealed the following: a. The deep fryer had food debris on the top and inside of the fryer, oil drippings down the front of the fryer, and oil and greasy debris build up on the floor beside the fryer. There was thick yellowish brown greasy buildup on the metal shield between the grill and the deep fryer. b. The floor in front of the stove and deep fryer had food debris and an oily substance that made it slippery to walk on. c. There were brown colored splatter marks all over the wall behind the two-compartment sink and the tea maker. d. Metal prep cart #1 had sticky brownish/yellow colored debris build up in the corners and sides of its surfaces. The bottom shelf had a large, sticky, yellowish colored stain that covered much of the shelf. There was a gray silverware tray that had a mixture of silverware, condiments, and food debris. d. The viewing glass on the steam table was covered with sticky liquid like splatters and drip marks. e. Three standing storage bins containing flour, sugar, and cornmeal had a sticky buildup present on the viewing lids and tops of the containers. f. The lower shelf of the metal prep table next to the fryer had food debris, crumbs, and greasy buildup. g. The lower shelf of the metal prep table by the microwave had food debris, crumbs, and a spilled white powdery substance . During observation and interview in the kitchen on 6/9/2026 at 2:30 PM, the Dining Services Manager (DSM) was shown the thick greasy build up on the shield between the stove and the deep fryer. The DSM stated, .That is a result of months and maybe years of buildup.We have called in an extra person to come and help with getting this place cleaned up.I walked through here this morning and I can tell you exactly what you saw before you even tell me. The DSM was shown the metal prep tables and stated .it definitely (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needs cleaned up . During observation and interview in the kitchen on 6/9/2026 at 2:40 PM, the DSM was shown the wall behind the tea maker and the two-compartment sink and confirmed that it would need to be cleaned. During observation and interview in the kitchen on 6/9/2026 at 2:45 PM, the DSM was shown the metal food prep carts and confirmed they needed to be cleaned. When shown the viewing glass on the steamtable the DSM stated .I am going to make sure that gets cleaned today . During observation and interview in the kitchen on 6/9/2026 at 2:48, the DSM was shown the standing storage bins containing flour, sugar, and cornmeal, and confirmed that all three lids needed to be cleaned. Observations in the kitchen on 6/10/2026 at 12:12 PM, revealed [NAME] E used his gloved hands multiple times to pull the stringy melted cheese completely onto the plate or pull the melted cheese apart and drop it back into the food pans. Observation in the kitchen on 6/10/2026 at 12:34 PM and 12:44 PM revealed [NAME] E used his plastic apron to wipe food off the edge of the resident's lunch plate. Observations in the kitchen during lunch-time steamtable temperature checks on 6/10/2026 at 12:50 PM, revealed [NAME] E wiped the thermometer on his plastic apron twice to clean the probe off before going to the next food. [NAME] E did not use alcohol wipes to disinfect the thermometer probe until he was prompted by the DSM. Observation in the kitchen on 6/10/2026 at 2:30 PM, revealed [NAME] E used the chemical testing strips from the dishwasher unit to test the chemicals in the 3-compartment sink, which showed no results when placed in the water. [NAME] E asked Dishwasher F if she knew what to use to test the water. Dishwasher F stated, I don't know.I've never been trained on that. [NAME] E had to ask the Kitchen Director of Operations to show him how to check the chemical level in the 3-compartment sink. During an interview in the Dining Room on 6/10/2026 at 2:40 PM, the Kitchen Director of Operations and the DSM confirmed that the kitchen needed to be cleaned and that a better system needed to be in place to educate the staff on kitchen sanitation and food preparation. The DSM stated that the staff did not know they were supposed to be keeping track of the 3-compartment sink's chemical levels and that she had made a chart that morning to hang up beside the sinks for staff to document the chemical levels, and would need to inservice them. The DSM confirmed the staff needed education on how to test the chemicals in the 3-compartment sink. The DSM confirmed [NAME] E should not have used his apron to clean off the plates or the thermometer probe while working at the steam table. The Kitchen Director of Operations stated .the staff really just needs a lot more education.They have had no one really train them and they need more help in there.

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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 maintainˆthe prevention and spread of infection during catheterˆcare and during Percutaneous Endoscopic Gastrostomy (PEG) medication administration for 2 of 2 (Resident #8 and Resident #80) sampled residents reviewed for the use of an indwelling urinary catheter and medication administration. The findings include:ˆ ˆ1. Review of the facility policy titled, Indwelling Catheter Use and Removal, dated 4/2026, revealed .If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards . ˆ Review of the facility policy titled, Infection Prevention and Control Program, dated 4/2026, revealed .All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE. Review of the facility policy titled, Care and Treatment of Feeding Tubes, dated 4/20/2026, revealed .It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.In accordance with facility protocol, licensed nurses will monitor and check that the feeding tube is in the right location.Tube placement will be verified before beginning a feeding and before administering medications. Review of the facility policy titled, Enhanced Barrier Precautions, dated 4/1/2026, revealed It is policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced Barrier Precautions [EBP] refer to an infection control intervention designed to reduce transmission of multi-drug organisms that employs targeted gown and gloves use during high contact resident care activities.Enhanced barrier precautions will be utilized for residents with any of the following.indwelling medical devices.feeding tubes. Review of the facility policy titled, Hand Hygiene, dated 4/2026, revealed .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors. Review of the facility policy titled, Enhanced Barrier Precautions, dated 1/2026, revealed .Enhanced barrier precautions will be utilized for residents with any of the following.indwelling medical devices (e.g.[example].urinary catheters.PPE for enhanced barrier precautions is only necessary when performing high contact care.High-contact resident care activities include.Device care or use: central lines, urinary catheters. ˆ ˆ2. ˆReview of medical record revealed Resident #8 was admitted on [DATE], with diagnoses including Chronic Kidney Disease Stage 4 and Neuromuscular Dysfunction of Bladder (Nerve damage to the bladder). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #8 scored a 5 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was severely cognitively impaired. Resident #8 was dependent on staff to perform activities of daily living (ADLs) and had a foley catheter. Review of the Physician's Order dated 1/16/2026, revealed .Catheter Care Every Shift . Review of the Physician's Order datedˆ3/27/2026, revealed .Enhanced Barrier Precautions: Chronic Foley [indwelling urinary catheter] Catheter . Random observationˆinˆthe resident'sˆroom onˆ6/9/2026ˆat 7:27 AM and 8:56 AM,ˆrevealedˆResident #8'sˆindwelling urinary catheter bag touching the floor.ˆˆ Observation and interview in the resident's room, on 6/9/2026 at 9:47 AM, revealed Resident #8's indwelling urinary catheter bag touching the floor. Licensed Practical Nurse (LPN) A was asked if any part of the urinary catheter should touch the floor. LPN A stated, .No it shouldn't . During an interview on 6/10/2026 at 8:11 AM, the Unit Manager LPN B was asked if the urinary catheter bag should be touching the floor. The Unit Manager LPN B stated, Never. The Unit Manager LPN B was asked what the complications of the urinary catheter bag touching the floor were. The Unit Manager LPN B stated, Infection. During an interview on 6/10/2026 at 8:45 AM, the Director of Nursing (DON) was asked, if a urinary catheter bag should ever be touching the floor. The DON stated, No. During an observation and interview in the resident's room on 6/10/2026 at 11:06 AM, Certified Nursing Aide (CNA) C was performing urinary catheter care. CNA C entered Resident #8's room, performed hand hygiene, applied gloves, and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	performed urinary catheter care. CNA C then removed her gloves and performed hand hygiene. CNA C was asked if Resident #8 was in Enhanced Barrier Precautions (EBP). CNA C asked, What is that. CNA C was shown EBP signage on the resident's door and was asked if the signage indicated Resident #8 was in EBP. CNA C stated, .Yes. CNA C was asked according to the EBP signage, should a gown have been worn during the urinary catheter care. CNA C stated, Yes. During an interview on 6/10/2026 at 11:42 AM, the DON was asked if she would expect her staff to know what Enhanced Barrier Precautions were and what to wear with Enhanced Barrier Precautions. The DON stated, Yes. The DON was asked if she would expect her staff to wear the proper PPE during urinary catheter care. The DON stated, I would. The DON was asked what she expected the staff to wear while performing urinary catheter care. The DON stated, Gown and gloves. 3. Review of the Medical Record revealed Resident #80 was admitted to the facility on [DATE], with diagnosis including Gastrostomy Status, Traumatic Brain Injury, Heart Failure, and Dysphagia. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #80 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment, which indicated she was cognitively intact. Review of a Physicians Order dated 2/12/2026, revealed .levetiracetam solution [used to treat seizures] 100 mg [milligram].Administer 10ml [milliliter] via [route] peg tube two times a day.metoclopramide [used to treat slow stomach emptying].5mg.1 TABLET po [by mouth] THREE TIMES A DAY. Review of the Physician Order dated 2/16/2026, revealed .Residuals [the amount of fluid/food remaining in the stomach].Check and record residuals and contact provider if residual exceeds 100 ml [milliliters]. Review of the Physician Order dated 2/20/2026, revealed .valproic acid [used to treat seizures].250 mg/5ml.gastric tube.Administer 10 ml by mouth three times a day. Review of the Physician Order dated 3/9/2026, revealed .Enteral Jevity [therapeutic nutrition] 1.5 @ [at] 30 cc/hr [cubic centimeters]/[hour] x [times] 12 hours. Observation outside of Resident #80's room during medication administration on 06/09/2026 at 2:15 PM, revealed Licensed Practical Nurse (LPN) D prepared Levetiracetam 10 ml, Metoclopramide 5 mg, and Valproic Acid 10 ml for administration and put gloves on at the medication cart, went to Resident #80's room, knocked on the door and entered. LPN D placed the medication on the bedside table. LPN D told Resident #80 he was going to give her medication, and she (Resident #80) requested him to put it through her peg tube. LPN D did not put a gown on before the administration of medication. LPN D started with a syringe containing 15-20 cc of water and flushed the peg tube. LPN D did not check placement or residual prior to the medication administration. LPN D then proceeded to administer the levetiracetam 10 ml via tube per syringe push, followed by a 15-20 ml water flush, next the valproic acid 10 ml via syringe push was administered, followed by a 15-20 ml water flush, lastly the metoclopramide crushed tablet in water via syringe push was administered with a 15-20 ml water flush. When LPN D completed administration of the medications he walked into Resident #80's bathroom, washed the syringe out and put it back in the plastic sleeve holder, walked to the resident's bedside and hung it on the pole. LPN D walked outside of room, to the medication cart with gloved hands and took off his gloves at the medication cart and threw them away. LPN D failed to wear the appropriate Personal Protective Equipment for EBP, failed to remove his gloves in Resident #80's room, and failed to perform hand hygiene. During an interview on 6/10/2026 at 8:47 AM, the Director of Nurses (DON) was asked if she would expect a staff member to check residual and placement on a peg tube before administration of medication and water. The DON stated, Yes. The DON was asked if she would expect staff to wear PPE with medication administration with a peg tube. The DON stated. Yes. The DON was asked should a staff member wear dirty gloves in the hallway. The DON stated, No, you should take them off in the room and use hand sanitizer.