

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER The Waters of Smyrna, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Enon Springs Road East Smyrna, TN 37167	

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)
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure 3 of 4 vulnerable sampled residents (Residents #6, #7, and #18) reviewed for abuse were free from sexual abuse by Resident #10. On an unknown date, Resident #6, who had a Brief Interview of Mental Status (BIMS) score of 15, which indicated no cognitive impairment, and had a diagnosis of Spastic Quadriplegia with Cerebral Palsy, stated Resident #10, who had a BIMS score of 15, which indicated no cognitive impairment, made nonconsensual sexual advances toward her by touching her hair and rubbing her on the thighs without permission. Resident #6 stated Resident #10 continued to rub on her thighs and antagonized her during activities. Resident #6 stated she was fearful and uncomfortable around Resident #10. On an unknown date, Resident #7, who had a BIMS score of 11, which indicated moderate impaired cognition, stated Resident #10 made nonconsensual sexual propositions, grabbed her hand, and rubbed her thighs. Resident #7 stated that she didn't want Resident #10 around her or touching her without permission because he made her feel uncomfortable. On 6/11/2024, Resident #18, who had a BIMS score of 15, which indicated no cognitive impairment, stated that she reported to the Activities Director, Administrator, and Director of Nursing (DON) that Resident #10 came into her room and demanded that she give him a kiss then motioned toward her. Resident #18 stated she yelled for Resident #10 to get out my room.</p> <p>The facility's failure to prevent sexual abuse for Residents #6, #7, and #18 resulted in Immediate Jeopardy (IJ). Immediate Jeopardy (IJ) is 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.</p> <p>The Administrator and Director of Nursing (DON) were notified of the IJ on 6/14/2024 at 2:00 PM in the Administrator's office.</p> <p>The facility was cited at F-600 at a scope and severity of K, which constitutes Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective on 2/12/2024 and is ongoing.</p> <p>A partial extended survey was conducted on 6/14/2024 to 6/21/2024.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>The findings include:</p> <p>Review of the facility policy titled, Abuse Prevention Program, dated 10/22/2022 revealed, .It is the policy of this facility to prevent resident abuse, neglect, mistreatment .Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party .Staff should report their knowledge of allegations without fear of reprisal .employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator. The Administrator is the Abuse Coordinator .Such reports may be made without fear of retaliation .Upon learning of the report, the Administrator .shall initiate an incident investigation .IF YOU SUSPECT ABUSE .separate the alleged perpetrator and assure all residents safety .Residents who allegedly mistreat another resident will be immediately removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents .As part of the social history assessment and MDS [Minimum Data Set] assessment, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict . Through the care planning process, staff will identify any problems .which reduce the chances of mistreatment for these residents .Abuse: the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, mental anguish or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being .Sexual Abuse: Including, but not limited to, sexual harassment, sexual coercion or sexual assault .</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Spastic Quadriplegic Cerebral Palsy, Bipolar Disorder, Aphasia, Anxiety Disorder, and Depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #6 revealed a BIMS score of 15 which indicated no cognitive impairment. Further review revealed impairment on one side to the upper extremity (shoulder, elbow, wrist, hand), impairment on both sides of the lower extremity (hip, knee, ankle, foot), and motorized wheelchair used for mobility.</p> <p>Review of the Comprehensive Care Plan dated 4/17/2024 for Resident #6 revealed no interventions were added to address sexual abuse.</p> <p>During observation and interview on 6/12/2024 at 8:02 AM, Resident #6 stated, .I had issues with [Named Resident #10]. [Named Resident #10] keeps rubbing my leg. [Named Resident #10] reaches toward me to hold my hands. I tell him to stop, but he doesn't and just laughs. I don't want another man touching me. He does it to other women. He yells at the staff and other residents all the time. I have reported the incidents to the Administrator and DON, and they told me they were going to handle it by getting [Named Resident #10] transferred. The first incident occurred last summer around June [2023] and continues to happen. Sometimes I don't want to leave my room because [Named Resident #10] makes me feel uncomfortable, and I don't want to be around him. The Administrator and DON keep telling me they are working on doing something about the incidents. I don't want to keep talking about the incidents because I don't want to get kicked out the facility for seeming like I'm causing problems due to reporting the incidents .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the medical record for Resident #6 revealed no documentation of Resident #10's sexual abuse until 6/15/2024.</p> <p>Review of the Telemedicine-Psychiatric Periodic Evaluation dated 6/15/2024 for Resident #6 revealed, . [Resident #6] is being seen by request of DON for an incident that occurred with [Resident #10] .DON present during visit .[Resident #6] states she was scared .</p> <p>Review of the Psychiatric Periodic Evaluation dated 6/18/2024 for Resident #6 revealed, . [Resident #6] states she wishes everyone would quit talking about the incident [involving Resident #10] .She states she is worried about retaliation. Discussed with [Resident #6] there would be no retaliation tolerated .</p> <p>Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Polyneuropathy, Parkinson's Disease, Anxiety Disorder, and Dementia.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate impaired cognition.</p> <p>Review of the Comprehensive Care Plan dated 5/2/2024 revealed no interventions were added to address sexual abuse.</p> <p>During observation and interview on 6/12/2024 at 7:52 AM, Resident #7 stated, .I have had issues with [Named Resident #10]. I don't remember the exact dates. He always reaches to hold my hand. I would slap his hands away. I reported the incident to the Administrator. I am unsure if they are doing anything about it. [Resident #10] says the most inappropriate things sometimes. [Named Resident #10] makes me feel uncomfortable, and I don't want to be around him . Resident #7 was asked if she could share some of the comments Resident #10 had made. Resident #7 stated, .I rather not go into detail about the comments. [Named Resident #10] causes issues all the time during activities by trying to touch on other women and yelling at staff and other residents. [Named Resident #6] is another woman here in the facility that he has touched on. Now, I'm done speaking with you about this situation .</p> <p>Review of the medical record for Resident #7 revealed no documentation of Resident #10's sexual abuse until 6/15/2024.</p> <p>Review of the Telemedicine-Psychiatric Periodic Evaluation dated 6/15/2024 revealed, .[Resident #7] is being seen by request of DON for an incident that occurred with another resident. [Resident #7] stated she doesn't want to talk about the incident .</p> <p>Review of the Psychiatric Periodic Evaluation dated 6/18/2024 revealed, .[Resident #7] states she doesn't want to talk about the incident .</p> <p>Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due to Excess Calories, and Anxiety Disorder.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the Comprehensive Care Plan dated 5/23/2024 revealed, .[Named Resident #10] has an alteration in behaviors as evidenced by: yelling at staff and others at times. 4/19/23 verbally aggressive with others. 6/8/23 [2023] verbally loud and argumentative with staff and other residents. 2/8/24 [2024] verbally agitated with staff and residents. 2/21/24 [2024] throwing objects out of room into hallway, verbal threats. 3/17/24 [2024] cursing staff, throwing things in room, banging on his garbage can . Further review revealed no interventions were included to address allegations of sexually inappropriate behaviors.</p> <p>During observation and interview on 6/13/2024 at 11:00 AM, Resident #10 stated, .I was sent out yesterday [6/12/2024] because I told [Named Resident #18] to give me a kiss on Tuesday [6/11/2024], and she told on me . Resident #10 was asked if the Administrator or DON had talked to him about the incident. Resident #10 stated, .The Administrator told me to watch my behaviors and conduct . Resident #10 was asked had he had any issues before with residents. Resident #10 smirked and laughed, then stated, .I had a resident report that I was rubbing her hair .</p> <p>Review of the medical record revealed no documentation for Resident #10 regarding sexual abuse or sexual behaviors prior to 6/15/2024.</p> <p>Review of the Telemedicine-Psychiatric Periodic Evaluation dated 6/15/2024 revealed, .[Resident #10] states he doesn't know why he did it. He states he knows better. He states he understands he can be charged with assault. He admits to having touched others [other residents] inappropriately and without consent .</p> <p>Review of the Psychiatric Periodic Evaluation dated 6/18/2024 revealed, .[Resident #10] states he knows what he did was wrong .</p> <p>Review of the medial record revealed Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Acute Pyelonephritis, Muscle Wasting and Atrophy Right Shoulder, Weakness, Difficulty in Walking, and Muscle Wasting and Atrophy Left Shoulder.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/14/2024 revealed no interventions were added to address allegations of sexual abuse.</p> <p>During observation and interview on 6/12/2024 at 6:35 PM, Resident #18 stated, . [Named Resident #10] came into my room and demanded I give him a kiss. Then, proceeded to come toward me. I yelled for him to get out my room. [Resident #10] looked at me and laughed then left out my room. I will fight him if he tries that again in order to protect myself. I notified the Administrator, DON, and Activities Director of the incident .</p> <p>Review of the medical record for Resident #7 revealed no documentation of Resident #10's sexual abuse until 6/15/2024.</p> <p>Review of the Telemedicine-Psychiatric Periodic Evaluation dated 6/15/2024 revealed, .[Resident #18] states she is bothered by the incident [Resident #10 entered Resident #18's room and asked for a kiss] .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the Psychiatric Periodic Evaluation dated 6/18/2024 revealed, .[Resident #18] states she is ready for this to be over with and not being discussed all the time .</p> <p>During an interview on 6/11/2024 at 2:24 PM, the Ombudsman stated, . On 2/12/2024, [Named Residents #6 and #7] reported to me that they were having issues with [Named Resident #10] touching them without permission. Both [Named Resident #6 and #7] stated they had reported the incidents to the Administrator and DON, but the issues with the unwanted touching continues. I spoke with the Administrator and DON regarding what was told to me by [Named Residents #6 and #7]. The facility hadn't put anything in place to address the incidents that were reported to them by the residents [Resident #6 and #7] .</p> <p>During an interview on 6/12/2024 at 9:48 AM, the DON stated, .Last year [2023] I believe there was incident between [Named Residents #6 and #10] about [Named Resident #10] touching [Named Resident #6]'s ponytail. I don't remember anything about [Named Resident #6] being touched inappropriately. The Administrator and I did speak with [Named Resident #10] about being mindful of others personal space and be aware of unwanted touching .</p> <p>During an interview on 6/12/2024 at 11:06 AM, the Administrator stated he was the abuse coordinator. The DON was his backup abuse coordinator. The Administrator stated, .I was aware of the incident between [Named Residents #6 and #10] regarding a ponytail being touched. [Named Resident #6] wanted [Named DON]'s help regarding [Named Resident #10] being rude and antagonizing her. [Named Resident #10]'s behaviors should be care planned. The Ombudsman did speak with me and the DON regarding concerns she about 2 residents [Residents #6 and #7] having issues with [Named Resident #10] . The Administrator was asked what he considers to be sexual abuse. The Administrator stated, .Sexual abuse would be when a staff member or resident touched another resident inappropriately . The Administrator was asked would he consider a resident constantly trying to grab and hold residents' hands or rubbing their legs without permission to be sexual abuse. The Administrator stated, . A resident can consider any touching unwanted .</p> <p>During an interview on 6/12/2024 at 4:16 PM, the Activities Director stated, .I've been having issues with [Named Resident #10] for over a year now. [Named Resident #10] places his hands wherever he can on female residents such as hands, legs, and thigh, then tells them you know you want it. I've witnessed those incidents during activities. Female residents are afraid of him. I report everything that occurs to the Administrator and DON and was told that as long as he doesn't hurt anyone there's nothing they can do .I witnessed [Named Resident #10] putting his hand on and rubbing [Named Resident #7]'s knee. I kept a log of the incidents involving [Named Resident #10] and gave it to the DON in a folder. Resident #10 thinks that touching on the female residents is fun, and he knows that it is wrong. I was told by the Administrator that I can't ask him to leave activities because he has a right to be there. It was also reported to me by [Named Resident #18] that [Named Resident #10] came into her room and demanded he kiss her. [Named Resident #10] has threatened to burn the building down and was looking for matches, and nothing was done. The Administrator and DON are well aware of the issues with [Named Resident #10] . The Activities Director was asked if she reported the incidents involving Resident #10 to any on other than the Administrator and DON, and she stated no.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/2024 at 10:50 AM, the Social Services Director (SSD) stated, .I have had concerns brought to me regarding [Named Resident #10] about the things he says and does . The SSD was asked what did he do when the residents' concerns were brought to him. The SSD stated, . By the time I would go speak with [Named Resident #10], [Named Resident #10] would be calm, and there would be no need to intervene .</p> <p>During an interview on 6/13/2024 at 1:00 PM, the DON stated, .[Named Administrator] is the abuse coordinator. I would consider a resident attempting to kiss another resident without permission sex abuse. [Named Resident #10] was sent out last night [6/12/2024] to the hospital for psychological evaluation due to behaviors . The DON was asked what were the behaviors that Resident #10 was exhibiting. The DON stated, .I believe he asked another resident to give him a kiss . The DON was asked when did the incident occur involving the kiss. The DON stated the day before [6/11/2024]. The DON was asked did she consider the incident between Residents #10 and #18 to be sexual abuse. The DON responded, .Yes, I would consider that incident to be sexual abuse . The DON was asked if she had been given a folder by the Activities Director regarding all the incidents and behavior involving Resident #10. The DON stated, .I will go look for it in my office .</p> <p>During an interview on 6/14/2024 at 2:00 PM, the DON stated that she could not find the folder that was given to her by the Activities Directors documenting the incidents and behaviors of Resident #10 during activities.</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to provide an environment free from the use of physical restraint used for staff convenience, that unnecessarily inhibited a resident ' s freedom of movement or activity for 1 of 3 (Resident #15) sampled residents reviewed for restraints. The facility also failed to obtain an order for the physical restraint, failed to document the medical symptom for which the restraint was implemented, failed to document less restrictive alternatives were implemented prior to use of the physical restraint, failed to document direct monitoring and supervision provided during use of the restraint, and failed to assess, care plan, and re-evaluate the need for the restraint. On 6/11/2024 and 6/12/2024, multiple observations revealed Resident #15, a vulnerable, severely cognitively impaired resident, sitting in the hallway, in front of the nurse station, in a geriatric chair (a large padded supportive recliner that can be placed in upright position or reclined) with a connected tray table across her lap. Resident #15 was unable to release the connected table and move freely in the chair. On 3/10/2024, Resident #15 sustained a skin tear that was reinjured on 4/6/2024, as a result of being restrained with a table tray, which resulted in an Immediate Jeopardy (IJ) with actual Harm. An Immediate Jeopardy is 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.</p> <p>The Interim Administrator, the Regional Nurse Consultant, and the Regional Director of Operations (via telephone) were notified of the Immediate Jeopardy on 6/21/2024 at 6:59 PM in the Administrator's Office.</p> <p>The facility was cited at F604 at a scope and severity of J, which constitutes Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective 3/10/2024 and is on-going. A partial extended survey was conducted on 6/14/2024 to 6/21/2024.</p> <p>The facility is required to submit a Plan of Correction (POC).</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Guidelines for Physical Restraints/Seclusion, dated 5/17/2023, revealed, .It is the policy of the facility to use physical restraint only as a last resort and only after every other alternative to a physical restraint (based on assessment) that seemed to have the potential for being used successfully, has been tried, and has failed. The use of a physical restraint and/or device is to enable and promote functioning at the highest practicable physical, mental, or psychosocial well-being. It will be used only after the resident has been assessed and it has been determined by the IDT [Interdisciplinary Team] that the restraint to be used is the least restrictive and for the least amount of time. A physical restraint is NEVER to be used for staff convenience or for discipline .Use of a physical restraint or device intervention is usually related to .Impaired Cognition and Communication .Decreased Safety Awareness .Impulsive with repeated attempts to stand/transfer without assistance from staff despite education and task segmentation . Unsuccessful attempts to use less restrictive devices .Unavoidable history of falls .Dementia/Alzheimer's . The resident must have a complete order for the restraint which includes the type of restraint and when it is to be applied/released. The restraint order must include the related medical condition. All physical restraints are to [be] released and the resident is to be repositioned at least every 2 hours .If the resident cannot remove the physical restraint device on command-and using the proper technique for removal-the device is considered a physical restraint .Procedure .Complete the initial Physical Restraint Assessment .If a resident is admitted with a physical restraint, a new assessment/order is needed .Review contributing factors such as behaviors/mood/fall risk/medical signs and symptoms/diagnosis/cognition/communication and ADL performance abilities .IDT to evaluate alternatives to physical restraint use and least restrictive interventions for the least amount of time .Explain and document the risk and benefits of treatment options related to physical restraints/devices to the resident as well as the representative/POA [Power of Attorney] .Obtain a detailed and specific doctor ' s order for the physical restraint/device which includes the specific physical restraint/device as well as when it is to be applied and released .Offer sensory stimulation and social interaction at intervals throughout the day with particular emphasis on the restraint release program-must be released at least q [every] 2 hours .Complete a new Physical Restraint/Device Assessment at least quarterly or if there is a change in the resident ' s condition (or if the medical condition for which the physical restraint is being used changes) to see if a lesser restraint can be used-or .discontinuance of the physical restraint if possible .The care plan must reflect the use of the physical restraint-to include medical conditions as well as releasing at least q 2 hours-and skin checks during use at time of application and removal-with nurse to assess skin as indicated .Always try a restraint alternative before using a physical restraint/device .</p> <p>Review of the facility policy titled, GUIDELINES FOR PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS), dated 6/18/2023, revealed, .Policy: It is the policy of the facility to follow the orders of the physician .The facility will have orders to provide essential care to the resident, consistent with the resident ' s mental and physical status upon admission .Procedure: 1) c. Routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan .2) As assessments are completed, orders will be received from the physician to address significant findings of the assessment .4) All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received .</p> <p>Review of the facility policy titled, Dressing Change, Clean, dated 1/1/2024, revealed, .ASSESSMENT GUIDELINES: General condition of skin .Mobility status .CARE PLAN DOCUMENTATION GUIDELINES . Consider listing possible risks and complications .Identify the cause of the condition .</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, dated 3/23/2021, revealed, .The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues .</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, and Seizures.</p> <p>Review of the Physician's Orders dated 12/5/2023 to 6/20/2024, revealed Resident #15 had no order for the table tray attached to a geriatric chair.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 2 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 required substantial/maximal assistance to sit to stand, chair/bed to chair transfer, and walking 10 feet was not attempted due to medical conditions or safety concerns. Further review of the MDS revealed Resident #15 was not coded for a restraint.</p> <p>Review of the care plan for Resident #15 revealed, .[12/6/2023] [named Resident #15] has indicated the following daily preferences are important to her; She sits in a [named] geriatric chair for comfort with an activity table provided by son .[3/21/2024] at risk for developing a pressure ulcer and/or alteration in skin integrity due to bowel and bladder incontinence, impaired bed mobility, cognition, and disease process. She requires assistance with bed mobility, transfers, and toileting .[3/10/24] skin tear right lower leg . Continued review revealed no care plan for a restraint to the geriatric chair.</p> <p>Review of the Medication Administration Record (MAR) for Resident #15 dated 3/1/2024 to 3/31/2024, revealed no documentation of a physical restraint.</p> <p>Review of the Treatment Administration Record (TAR) for Resident #15 dated 3/1/2024 to 3/31/2024, revealed no documentation of a physical restraint.</p> <p>Review of the facility progress note dated 3/10/2024 at 1:58 PM, revealed Registered Nurse (RN) OO documented, .INFORMED BY CNA THAT RESIDENT [Resident #15] SUSTAINED SKIN TEAR TO RIGHT LOWER EXTREMITY FROM [named geriatric] CHAIR. ON ASSESSMENT, BLEEDING SKIN TEAR WITH DETACHED SKIN FLAP, 7.5 CM [centimeter] LONG NOTED TO RIGHT LATERAL CALF .AREA WAS CLEANSED WITH WOUND CLEANSER AND COVERED WITH BORDER GAUZE. RP [responsible party] AND WOUND CARE NURSE NOTIFIED .</p> <p>Review of the MAR for Resident #15 dated 4/1/2024 to 4/30/2024, revealed no documentation of a physical restraint.</p> <p>Review of the TAR for Resident #15 dated 4/1/2024 to 4/30/2024, revealed no documentation of a physical restraint.</p> <p>Review of the facility progress note dated 4/6/2024 at 7:23 PM, revealed the DON documented, resident observed anxious/restless while in wheelchair in hall. this nurse observed resident with small amount of dark red blood on lower left outer leg. observed small skin tear in forestated area on resident's leg. resident continuously rubbing leg on parts of [named geriatric] chair d/t [due to] restlessness. resident unaware d/t current cognitive status.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the MAR for Resident #15 dated 5/1/2024 to 5/31/2024, revealed no documentation of a physical restraint.</p> <p>Review of the TAR for Resident #15 dated 5/1/2024 to 5/31/2024, revealed no documentation of a physical restraint.</p> <p>Review of the Weekly Wound Evaluation dated 5/8/2024 revealed, . Right lower leg (front) .Skin Tear .</p> <p>Review of the TAR for Resident #15 dated 6/1/2024 to 6/21/2024, revealed no documentation of a physical restraint and documentation that daily treatments were performed on Resident #15's right leg skin tear.</p> <p>Observation at the 100/200 hall at the nurse's station on 6/11/2024 at 9:50 AM, revealed Resident #15 was sitting in a geriatric chair with a connected tray across her. The table tray was without any activity supplies in front of Resident #15. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation at the 100/200 hall at the nurse's station on 6/11/2024 at 10:46 AM, revealed Resident #15 was sitting in a geriatric chair with a connected tray across her. The table tray was without any activity supplies in front of Resident #15. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation in the dining room on 6/11/2024 at 12:22 PM, revealed Resident #15 was sitting in a geriatric chair with a connected tray across her. Resident #15 was delivered her meal on top of the connected tray. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation in the resident's room on 6/11/2024 at 1:20 PM, revealed Resident #15 was brought back out to the nurse ' s station in the geriatric chair with the tray table across her. No activity supplies were observed on the tray table. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation at the 100/200 nurses' station on 6/11/2024 at 2:10 PM, revealed Resident #15 was sitting in the geriatric chair with a piece of paper on her tray table across the resident. Resident #15 was pulling on the tray with both hands and raising her bottom off the seat. Staff failed to respond to Resident #15 pulling on the tray table and raising her bottom off the seat. Resident #15 then laid her head over to rest on the adjacent wall. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation at the 100/200 nurses' station on 6/11/2024 at 2:20 PM, revealed Resident #15 continued to sit in the geriatric chair with a piece of paper on the tray table across the resident. Resident #15 reached for a Certified Nursing Assistant (CNA) walking by and stated, Come on let's go. The CNA patted her hand and walked away. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Observation in the dining room on 6/11/2024 at 3:00 PM, revealed Resident #15 was sitting in the geriatric chair with a tray table across the resident. Resident #15's tray remained over the resident during a movie. Resident #15 was noted pulling on the tray lifting her buttocks off of the seat. No staff responded to the resident pulling on the tray and lifting her buttocks off of the seat. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation at the 100/200 nurses' station on 6/11/2024 at 4:05 PM, revealed Resident #15 was sitting in the geriatric chair with tray across the resident. Resident #15 scooted the geriatric chair with her feet in a walking motion for two steps. No staff responded to Resident #15 moving the geriatric chair. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation in the resident's room on 6/11/2024 at 4:45 PM, revealed Resident #15 was being pushed in the geriatric chair from her room with a tray table across her. Resident #15 had no activities on her tray in front of her. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Observation at the 100/200 nurses' station on 6/12/2024 at 11:18 AM, Resident #15 was sitting in her geriatric chair with a tray table across the resident. Resident #15 was sleeping. Continued observation revealed Resident #15's left forearm was wrapped with gauze and a bandage was noted to the front of her right leg.</p> <p>Review of the medical record revealed no documentation for the bandages to Resident #15's left forearm.</p> <p>During an interview on 6/11/2024 at 4:10 PM, CNA F stated, "[Named Resident #15] has been in the [named chair] since I started working here. I [I've] been here about 8 months .she is not able to remove the tray .she will raise herself up in the chair .she needs assistance with walking . CNA F was asked if Resident #15 ever asks to remove the table tray and was she (CNA F) trained on the use of the geriatric chair. CNA F stated, . she doesn ' t ask for it to be removed .I haven't had training on the use of the [named chair] .I don't know of any other residents that use a tray or any pad alarms .</p> <p>During an interview on 6/11/2024 at 4:14 PM, Licensed Practical Nurse (LPN) O stated, .I have been at the facility for 7 months .[Named Resident #15] has had the [named geriatric chair] and tray since I have been here .if the tray is loose, I make sure the tray is secured .She doesn't ask for it to be removed .she can ' t remove it .She will get angry and shake the tray .she is a big fall risk .I would assume the chair and tray was for her safety .she has seizures .I don't see an assessment for the chair or tray .if a resident has behaviors the CNAs don't chart that they just come tell the nurses .I don't see an order for the [named geriatric chair] and tray .</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/11/2024 at 4:20 PM, the MDS Coordinator stated, "[Named Resident #15] got the chair a week after she came [admitted to the facility] .she was trying to get up and kept falling and hurting herself .she should have some type of activity on her tray at all times .snacks, magazines, anything to occupy her .she is happy with something to do .she has Alzheimer's .she is a safety risk . The MDS Coordinator was asked what risk factors are present when placing a resident in a geriatric chair with a tray secured over the resident. The MDS Coordinator stated, .it could be considered a restraint, but it helps keep everything in front of her .we do not document when the tray has been released .I have never known of her asking to remove the tray .the Activities of Daily Living (ADL) charting would show when it was released .we haven't done a device assessment .</p> <p>Review of the medical record revealed the ADL charting did not document when the restraint was released.</p> <p>During an interview on 6/12/2024 at 7:52 AM, the Director of Nursing (DON) stated, .I can't say that the staff had any training [related to named geriatric chair] .typically we don't allow that type of chair . The DON was asked if the facility could physically restrain a resident at the family's request, she stated, No. The DON was asked the medical symptom for the physical restraint. The DON stated, .previous falls and behaviors upon admission .it could be seen as a restraint if the resident was not provided food, snacks, magazines, or activities on her tray .It is not used as a restraint if it is used for activities . The DON was asked what the benefits of the physical restraint are. The DON stated, .it's keeping her safe, prevented falls .she can't remove the tray .she is always at the nurse's desk and on the get up list first thing in the morning .the staff know the tray has to make 2 sounds to verify it is locked in place . The DON was unable to provide an order, any assessments, consent for the use, or documentation of removal and timing of the release for the physical restraint.</p> <p>During an interview on 6/12/2024 at 8:15 AM, Registered Nurse (RN) X stated, "[Named Resident #15] can't remove the tray .I don't know of any documentation we do on it when it is released .She will shake the tray when she is frustrated, to go to the bathroom .</p> <p>During a telephone interview on 6/12/2024 at 9:07 AM, Family Member (FM) Y stated, .I didn ' t request that chair .it was suggested to me to help decrease her falls .I have been shown on how the tray functions, but nothing was discussed with me about the risk of the chair . FM Y was asked when he visits Resident #15 does she always have activities on her tray. FM Y stated, .it is about a 50/50 .I don ' t think I signed a consent [for a restraint] for the facility .she was having multiple falls .I don ' t know of any injuries she has had related to the chair .</p> <p>During an interview on 6/12/2024 at 4:35 PM, the Activity Director stated, "[Named Resident #15] can't remove the tray .she gets angry and frustrated and will try to climb out of the chair .I don ' t know of any set time to release the tray .I haven't been told to remove it during activities .I never see her without the tray .</p> <p>During an interview on 6/12/2024 at 5:15 PM, LPN W stated, .I don't know why [Named Resident #15] has the tray across her .I would consider that tray a restraint .she can't remove it .I thought nursing homes quit using those [restraints] years ago .</p> <p>(continued on next page)</p>		

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<p>F 0604</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/13/2024 at 9:05 AM, the Physical Therapy Director stated, .today is the first time I have evaluated [Named Resident #15] for a sitting device [Rocking recliner wheelchair that can tilt back 30 degrees] .</p> <p>During an interview on 6/13/2024 at 10:10 AM, the MDS Coordinator was asked why the Quarterly MDS does not reflect the use of a chair that prevents rising. The MDS Coordinator stated, .well, she didn't have the tray on all the time .</p> <p>During a telephone interview on 6/20/2024 at 11:46 PM, the facility Nurse Practitioner (NP) stated a table tray could be placed in front of a resident if the resident had the mental capacity to remove it themselves. When asked if Resident #15 had the mental capacity to remove a tray table, the NP replied, No, Resident #15 does not have the mental capacity to remove a table tray.</p> <p>During an interview on 6/21/2024 at 12:40 PM, the Wound Care Nurse (WCN) stated Resident #15 tried to get up from the geriatric chair with a table tray connected and sustained a skin tear to the front right lower leg on 3/10/2024. The WCN stated the skin tear was healing when Resident #15 reinjured the same skin tear on 4/6/2024 trying to get out of the geriatric chair with the table tray connected. Continued interview revealed the WCN was asked why Resident #15's arm was wrapped with gauze. The WCN replied, There is nothing wrong with her [Resident #15] arm. Some nurse wrapped it because she [Resident #15] had some swelling to her elbow. When asked about the bandage on Resident #15's leg, the WCN replied, Her [Resident #15] skin tear was from the [named] geriatric chair.</p> <p>During an interview on 6/21/2024 at 1:15 PM, the MDS Coordinator stated she could not find any documentation related to an assessment, physician's order, or monitoring of the table tray connected to the geriatric chair of Resident #15.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>Based on facility policy review, medical record review, police report review, and interview, the facility failed to report allegations of sexual abuse to the State Survey Agency (SSA) for 3 of 4 (Residents #6, #7, and #18) sampled residents reviewed. On an unknown date, Resident #6, who had a diagnosis of Spastic Quadriplegia with Cerebral Palsy, stated Resident #10 made nonconsensual sexual advances toward her by touching her hair and rubbing her on the thighs without permission. Resident #6 stated Resident #10 continued to rub on her thighs and antagonized her during activities to the point where she is fearful and uncomfortable around Resident #10. On an unknown date, Resident #7 stated Resident #10 made nonconsensual sexual propositions, grabbed her hand, and rubbed her thighs. Resident #7 stated that she doesn't want Resident #10 around her or touching her without permission because he made her feel uncomfortable. On 6/11/2024, Resident #18 stated that she reported to the Activities Director, Administrator, and Director of Nursing (DON) that Resident #10 came into her room and demanded that she give him a kiss then motioned toward her. Resident #18 stated she yelled for Resident #10 to get out my room.</p> <p>The facility also failed to report an allegation of suspected neglect to the SSA for 1 of 4 (Resident #9) sampled residents reviewed. Family Member (FM) ZZ contacted law enforcement and requested they do a welfare check at the skilled nursing facility. When law enforcement arrived at the facility, Resident #9 was tearful and reported an allegation of neglect. Resident #9 alleged she had attempted to contact her nurse Licensed Practical Nurse (LPN) B for needed medications. Resident #9 felt she was not being adequately cared for and did not receive her medication as scheduled.</p> <p>The finding include:</p> <p>Review of the facility policy titled, Abuse Prevention Program, dated 10/22/2022 revealed, .It is the policy of this facility to prevent resident abuse, neglect, mistreatment .The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party .Staff should report their knowledge of allegations without fear of reprisal .employees are required to report any incident, allegation or suspicion of potential abuse, neglect or mistreatment they observe, hear about or suspect to the Administrator. The Administrator is the Abuse Coordinator .Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated .Upon learning of the report, the Administrator .shall initiate an incident investigation .the Administrator or designee utilizing the Incident Reporting System will immediately notify the Department of Health by the online system .All incidents will be documented, whether or not abuse occurred was alleged or suspected .The final investigation report will be completed within the required timeframe .</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Spastic Quadriplegic Cerebral Palsy, Bipolar Disorder, Anxiety Disorder, and Depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Comprehensive Care Plan dated 4/17/2024 revealed no interventions to address allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 8:02 AM, Resident #6 stated, .I had issues with [Named Resident #10]. [Named Resident #10] keeps rubbing my leg. [Named Resident #10] reaches towards me to hold my hands. I tell him to stop, but he doesn't and just laughs. I don't want another man touching me. He does it to other women. I have reported the incidents to the Administrator and DON, and they told me they were going to handle it. The first incident occurred last summer around June 2023 and continues to happen .</p> <p>Review of medical record revealed Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Parkinson's Disease, Anxiety Disorder, and Dementia.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/2/2024 revealed no interventions to address allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 7:52 AM, Resident #7 stated, .I have had issues with [Named Resident #10]. I don't remember the exact dates. He always reaches to hold my hand. I would slap his hands away. I reported the incident to the Administrator. I am unsure if they are doing anything about it .</p> <p>Review of medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due to Excess Calories, and Anxiety Disorder.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan revealed, .[Named Resident #10] has an alteration in behaviors as evidenced by: yelling at staff and others at times. 4/19/23 [4/19/2023] verbally aggressive with others. 6/8/23 [6/8/2023] verbally loud and argumentative with staff and other residents. 2/8/24 [2/8/2024] verbally agitated with staff and residents. 2/21/24 [2/21/2024] throwing objects out of room into hallway, verbal threats. 3/17/24 [3/17/2024] cursing staff, throwing things in room, banging on his garbage can . Further review revealed no appropriate interventions for allegations of inappropriate sexual behaviors.</p> <p>During an interview on 6/13/2024 at 11:00 AM, Resident #10 stated, .I was sent out yesterday [6/12/2024] because I told [Named Resident #18] to give me a kiss on Tuesday [6/11/2024], and she told on me . Resident #10 was asked had he any issues before with residents. Resident #10 smirked and laughed, then stated, .I had a resident report that I was rubbing her hair .</p> <p>Review of the medial record revealed Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Muscle Wasting and Atrophy Right Shoulder, Difficulty in Walking, and Muscle Wasting and Atrophy Left Shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Quarterly MDS dated [DATE] for Resident #18 revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan for Resident #18 revealed no interventions for allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 6:35 PM, Resident #18 stated, "[Named Resident #10] came into my room and demanded I give him a kiss. Then, proceeded to come toward me. I yelled for him to get out my room.[Resident #10] looked at me and laughed then left out my room. I will fight him if he tries that again in order to protect myself. I notified the Administrator, DON, and Activities Director of the incident .</p> <p>During an interview on 6/11/2024 at 2:24 PM, The Ombudsman stated, ".On 2/12/2024, [Named Residents #6 and #7] reported to me that they were having issues with [Named Resident #10] touching them without permission. Both [Named Residents #6 and #7] stated they had reported the incidents to the Adminitrator and DON, but the issues with the unwanted touching continue. I spoke with the Administrator and DON regarding what was disclosed to me by [Named Residents #6 and #7]. The facility hadn't put anything in place to address the incidents that were reported to them by the residents [Named Resident #6 and #7]. The Administrator and DON also stated that the incidents weren't reported to the state .</p> <p>During an interview on 6/12/2024 at 9:48 AM, The DON stated, ".Last year [2023] I believe there was incident between [Named Residents #6 and #10] about [named Resident #10] touching [Named Resident #6]'s ponytail. That is the only incident I can recall regarding [Named resident #10]. The incident wasn't reported to the state .</p> <p>During an interview on 6/12/2024 at 11:06 AM, the Administrator stated he was the abuse coordinator. The DON was his backup abuse coordinator. The Administrator stated, ".I was aware of the incident between [Named Residents #6 and #10] regarding a ponytail being touched .[Named Resident #6] wanted [Named DON]'s help regarding [Named Resident #10] being rude and antagonizing her. The Ombudsman did inform me and the DON regarding [Named Resident #10]'s behaviors [sexual] toward [Named Residents #6 and #7]. [Named Resident #10]'s behaviors should be care planned. The Ombudsman did speak with me and the DON regarding concerns she had about 2 residents [Named Residents #6 and #7] having issues with [Named Resident #10] . The Administrator was asked what is the protocol when abuse is reported to him. The Administrator stated, ".I follow the abuse policy, make sure the resident is safe, conduct an investigation, and report within 2 hours . The Administrator was asked if the incidents regarding Residents #6 and #7 were reported, and he stated no.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/12/2024 at 4:16 PM, the Activities Director stated, .I've been having issues with [Named Resident #10] for over a year now. During activities, he over talks residents and becomes very combative. [Named Resident #10] places his hands wherever he can on female residents such as hands, legs, and thighs. Then tells them you know you want it. I've witnessed those incidents during activities. Female residents are afraid of him. I reported everything that occurred to the Administrator and DON. I was told that as long as he doesn't hurt anyone there's nothing they can do. I witnessed [Named Resident #10] putting his hand on and rubbing [Named Resident #7]'s knee. I kept a log of the incidents involving [Named Resident #10] and gave it to the DON in a folder. I was told by the Administrator that I can't ask him to leave activities because he has a right to be there. It was also reported to me by [Named Resident #18] that [Named Resident #10] came into her room and demanded he kiss her. The Administrator and DON are well aware of the issues with [Named Resident #10] .</p> <p>During an interview on 6/13/2024 at 1:00 PM, the DON stated, .[Named Administrator] is the abuse coordinator. I would consider a resident attempting to kiss another resident without permission sexual abuse. [Named Resident #10] was sent out last night [6/12/2024] to the hospital for psychological evaluation due to behaviors . The DON was asked what type of behavior Resident #10 was sent out for. The DON responded, . I believe it was for attempting to kiss another resident . The DON was asked when did the incident occur involving the kiss. The DON stated the day before [6/11/2024]. The DON was asked if she would consider that a reportable incident. The DON stated, .Yes, the incident between [Named Resident #10 and #18] would be considered a reportable incident, but it was not reported to the state .</p> <p>Review of medical records revealed Resident #9 was admitted to the facility on [DATE] with readmission on 5/25/2024 with diagnoses which included End Stage Renal Disease, Dependence on Renal Dialysis, Acquired Absence of Right Leg Above the Knee, and Type 1 Diabetes Mellitus.</p> <p>Review of the Admission MDS assessment dated [DATE], revealed Resident #9 had a BIMS score was 15 which indicated no cognitive impairment. Continued review revealed Resident #9 requires the use of a wheelchair, had been occasionally incontinent of Bowel and Bladder, had a surgical wound, and required dialysis.</p> <p>Review of the undated Care Plan for Resident #9 revealed, Resident #9 was .at risk for an alteration in comfort related to diabetic polyneuropathy, chronic pain and Right AKA (above the knee amputation) . 4/12/2024 surgical wound to right AKA .impaired visual function .legally blind .</p> <p>Review of the police report dated 4/29/2024 at 4:18 AM, revealed Resident #9 submitted a report alleging neglect of an Elderly or Vulnerable Adult.On 4/29/2024 Family Member (FM) ZZ called local law enforcement related to a welfare check at [named facility's address]. Resident #9 was crying .she feared retaliation from staff for speaking out against them [the staff]. Named Resident #9 attempted to contact her nurse [LPN B] started at midnight and she was not available no one else could access the medication. The nurse appeared shortly after the police had arrived at the facility .Resident #9 alleged the facility was the cause of her lower limb amputation .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Waters of Smyrna, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Enon Springs Road East Smyrna, TN 37167	
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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/20/2024 at 12:24 PM, the Nurse Practitioner (NP) stated Resident #9 was a medically complex resident. Resident #9 was a brittle Diabetic, required dialysis and has had an amputation. Resident #9 psychologically had concerns with depression, anxiety and a lack of social support. The NP remembers being told about a time when Resident #9 had not been given her medication on the night shift but did not recall any pertinent details.</p> <p>During an interview on 6/17/2024 at 3:20 PM, LPN B stated Resident #9 had prescription for Vistaril (medication has been used for anxiety, nausea, vomiting and itching) that was requested more often than prescribed. LPN B said the technicians were intercepting Resident #9's phone calls for her because the medication was not available. LPN B stated the prescription had been changed from every 4 hours and Resident #9 was still requesting it be given that often.</p> <p>During an interview on 6/18/2024 at 10:00 AM. The Regional Director of Operations (RDO) stated he had reviewed the police report initiated by Resident #9 and noticed there was an allegation of neglect. The RDO stated the allegation should have been reported to the SSA within the 2-hour window. The RDO confirmed the allegation was not reported.</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46532</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to conduct an investigation and take appropriate corrective actions for 3 of 3 sampled residents (Residents #6, #7, and #18) reviewed for allegations of sexual abuse by Resident #10. On an unknown date, Resident #6, who had a Brief Interview of Mental Status (BIMS) score of 15, which indicated no cognitive impairment, and had a diagnosis of Spastic Quadriplegia with Cerebral Palsy, stated Resident #10, who also had a BIMS score of 15, made nonconsensual sexual advances toward her by touching her hair and rubbing her on the thighs without permission. Resident #6 stated Resident #10 continued to rub on her thighs and antagonized her during activities to the point where she is fearful and uncomfortable around Resident #10. On an unknown date, Resident #7, who had a BIMS score of 11, which indicated moderate cognitive impairment, stated Resident #10 made nonconsensual sexual propositions, grabbed her hand, and rubbed her thighs. Resident #7 stated that she doesn't want Resident #10 around her or touching her without permission because he makes her feel uncomfortable. On 6/11/2024, Resident #18, who had a BIMS score of 15, stated that she reported to the Activities Director, Administrator, and Director of Nursing (DON) that Resident #10 came into her room and demanded that she give him a kiss, then he motioned toward her. Resident #18 stated she yelled for Resident #10 to get out my room.</p> <p>The facility's failure to conduct an investigation and take appropriate corrective actions for sexual abuse for Residents #6, #7, and #18 resulted in Immediate Jeopardy (IJ). Immediate Jeopardy (IJ) is 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.</p> <p>The Administrator and DON were notified of the IJ on 6/14/2024 at 2:00 PM in the Administrator's office.</p> <p>The facility was cited at F-610 at a scope and severity of K, which constitutes Substandard Quality of Care.</p> <p>The Immediate Jeopardy was effective on 2/12/2024 and is ongoing.</p> <p>A partial extended survey was conducted on 6/14/2024 to 6/21/2024.</p> <p>The facility is required to submit a plan of correction (POC).</p> <p>The findings include:</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of the facility policy titled, Abuse Prevention Program, dated 10/22/2022, revealed, .It is the policy of this facility to prevent resident abuse, neglect, mistreatment .The Administrator is the Abuse Coordinator . Such reports may be made without fear of retaliation. Anonymous reports will also be thoroughly investigated .Upon learning of the report, the Administrator .shall initiate an incident investigation .IF YOU SUSPECT ABUSE .separate the alleged perpetrator and assure all residents safety .All incidents will be documented, whether or not abuse occurred was alleged or suspected .Upon receiving reports of physical or sexual abuse, the Charge Nurse will immediately examine the resident .Any incident or allegation involving abuse or mistreatment will result in an abuse investigation .A completed copy of the incident report and written statements from witnesses, if any, will be provided to the Administrator within twenty-four (24) hours of the occurrence of such incident. The final investigation report will be completed within the required timeframe . The facility will take steps to prevent mistreatment while the investigation is underway .Residents who allegedly mistreat another resident will be immediately removed from contact with that resident during the course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his or her safety, as well as the safety of the other residents .As part of the social history assessment and MDS [Minimum Data Set] assessment, staff will identify residents with increased vulnerability for abuse, neglect, mistreatment or who have needs and behaviors that might lead to conflict .Through the care planning process, staff will identify any problems . which reduce the chances of mistreatment for these residents .</p> <p>Review of the medical revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Spastic Quadriplegic Cerebral Palsy, Bipolar Disorder, Aphasia, Anxiety Disorder, and Depression.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Further review revealed impairment on one side to the upper extremity (shoulder, elbow, wrist, hand), impairment on both sides to the lower extremity (hip, knee, ankle, foot), and a motorized wheelchair used for mobility.</p> <p>Review of the Comprehensive Care Plan dated 4/17/2024 revealed no interventions to address allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 8:02 AM, Resident #6 stated, .I had issues with [Named Resident #10]. [Named Resident #10] keeps rubbing my leg. [Named Resident #10] reaches towards me to hold my hands. I tell him to stop, but he doesn't and just laughs. I don't want another man touching me. He does it to other women. I have reported the incidents to the Administrator and DON, and they told me they were going to handle it by getting [Named Resident #10] transferred. The first incident occurred last summer around June and continues to happen. Sometimes I don't want to leave my room because [Named Resident #10] makes me feel uncomfortable, and I don't want to be around him. The Administrator and DON keep telling me they are working on doing something about the incidents. I don't want to keep talking about the incidents because I don't want to get kicked out the facility for seeming like I'm causing problems due to reporting the incidents .</p> <p>Review of a Psychiatric Periodic evaluation dated 6/15/2024 revealed Resident #6 was seen per telemedicine with the DON present regarding the allegation she made of sexual abuse by Resident #10. Resident #6 reported she was scared.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>Review of a Psychiatric Periodic Evaluation dated 6/18/2024 revealed Resident #6 reported she was worried about retaliation. Resident #6 was reassured there would be no retaliation.</p> <p>The facility was unable to provide an investigation into the allegation of sexual abuse Resident #6 made regarding Resident #10.</p> <p>Review of medical record revealed Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Polyneuropathy, Parkinson's Disease, Anxiety Disorder, and Dementia.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate impaired cognition. Further review revealed Resident #7 used a manual wheelchair to maneuver.</p> <p>Review of the Comprehensive Care Plan dated 5/2/2024 revealed no interventions to address allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 7:52 AM, Resident #7 stated, .I have had issues with [Named Resident #10]. I don't remember the exact dates. He always reaches to hold my hand. I would slap his hands away. I reported the incident to the Administrator. I am unsure if they are doing anything about it. He [Resident #10] says the most inappropriate things sometimes. [Named Resident #10] makes me feel uncomfortable, and I don't want to be around him . Resident #7 was asked if she could share some of the comments Resident #10 made. Resident #7 stated, .I rather not go into detail about the comments. Resident #10 causes issues all the time during activities by trying to touch on other women and yelling at staff and other residents. [Named Resident #6] is another woman here in the facility that he has touched on. Now, I'm done speaking with you about this situation .</p> <p>Review of a Psychiatric Periodic evaluation dated 6/15/2024, revealed Resident #7 was seen per telemedicine by request of the DON regarding the allegation she made of sexual abuse by Resident #10. She stated she doesn't want to talk about the incident [Allegation of sexual abuse by Resident #10].</p> <p>Review of a Psychiatric Periodic Evaluation dated 6/18/2024 revealed Resident #7 reported that she didn't want to talk about the incident [Allegation of sexual abuse by Resident #10].</p> <p>The facility was unable to provide an investigation into the allegation of sexual abuse Resident #7 made regarding Resident #10.</p> <p>Review of medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due to Excess Calories, and Anxiety Disorder.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/23/2024, revealed Resident #10 exhibited behaviors of yelling at staff and others, verbal aggression, verbally loud and argumentative with staff and residents, verbal agitation with staff and residents, verbal threats, cursing staff, throwing objects into the hallway, throwing things in his room, and banging on his garbage can. Further review revealed no interventions were included to address allegations of sexually inappropriate behaviors.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/2024 at 11:00 AM, Resident #10 stated, .I was sent out yesterday [6/12/2024] because I told [Named Resident #18] to give me a kiss on Tuesday [6/11/2024], and she told on me . Resident #10 was asked if the Administrator or DON had talked to him about the incident. Resident #10 stated, .The Administrator told me to watch my behaviors and conduct . Resident #10 was asked had he any issues before with residents. Resident #10 smirked and laughed, then stated, .I had a resident report that I was rubbing her hair .</p> <p>Review of a Psychiatric Periodic Evaluation dated 6/15/2024 revealed Resident #10 was seen per telemedicine with the DON present regarding allegations of sexual abuse by Resident #10 toward Residents #6, #7, and #18. Resident #10 stated he doesn't know why he did it, and he knows better. Resident 10 stated he understands he can be charged with assault, and he admitted to having touched others inappropriately and without their consent.</p> <p>Review of a Psychiatric Periodic Evaluation dated 6/18/2024 revealed Resident #10 stated he knows what he did was wrong.</p> <p>Review of the medial record revealed Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Acute Pyelonephritis, Muscle Wasting and Atrophy, Right Shoulder, Weakness, Difficulty in Walking, Depression, Lack of Coordination, and Muscle Wasting and Atrophy, Left Shoulder.</p> <p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/14/2024 revealed no interventions for allegations of sexual abuse.</p> <p>During an interview on 6/12/2024 at 6:35 PM, Resident #18 stated, .[Named Resident #10] came into my room and demanded I give him a kiss. Then, proceeded to come toward me. I yelled for him to get out my room. I will fight him if he tries that again in order to protect myself. I notified the Administrator, DON, and Activities Director of the incident. [Named Resident #10] hadn't done that to me before .</p> <p>Review of a Psychiatric Periodic Evaluation dated 6/15/2024 revealed Resident #18 was bothered by the incident with Resident #10.</p> <p>Review of a Psychiatric Periodic Evaluation dated 6/18/2024 revealed Resident #18 stated she was ready for this to be over with and not to be discussed all the time.</p> <p>The facility was unable to provide an investigation into the allegation of sexual abuse Resident #18 made regarding Resident #10.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/11/2024 at 2:24 PM, the Ombudsman stated, .On 2/12/2024, [Named Residents #6 and #7] reported to me that they were having issues with [Named Resident #10] touching them without permission. Both [Named Residents #6 and #7] stated they had reported the incidents to the Administrator and DON, but the issues with the unwanted touching continues. I spoke with the Administrator and DON regarding what was told to me by [Named Residents #6 and #7]. The facility hadn't put anything in place to address the incidents that were reported to them by the residents [Resident #6 and #7] .</p> <p>During an interview on 6/12/2024 at 9:48 AM, the DON stated, .Last year [2023] I believe there was incident between [Named Residents #6 and #10] about [named Resident #10] touching [Named Resident #6]'s ponytail .The Administrator and I did speak with [Named Resident #10] about being mindful of others personal space and be aware of unwanted touching. That is the only incident I can recall regarding [Named resident #10] .</p> <p>During an interview on 6/12/2024 at 11:06 AM, the Administrator stated he was the abuse coordinator. The DON was his backup abuse coordinator. The Administrator stated, .I was aware of the incident between [Named Residents #6 and #10] regarding a ponytail being touched .[Named Resident #6] wanted [Named DON]'s help regarding [Named Resident #10] being rude and antagonizing her. We did speak with the Ombudsman regarding the incident and [Named Resident #10]'s behaviors. [Named Resident #10]'s behaviors should be care planned. That's the only incident I can recall being reported to me . The Administrator was asked what does he consider to be sexual abuse. The Administrator stated, .Sexual abuse would be when a staff member or resident touched another resident inappropriately . The Administrator was asked would he consider a resident constantly trying to grab and hold residents' hands or rubbing their legs without permission to be sexual abuse. The Administrator stated, .A resident can consider any touching unwanted. We have activities all the time where residents have to interact and touching may occur. Just like when a prayer occurs, residents have to hold hands, and a resident may consider that inappropriate . The Administrator was asked what is the protocol when abuse is reported to him. The Administrator stated, .I follow the abuse policy, make sure the resident is safe, conduct an investigation, and report within 2 hours . The Administrator was asked if the incidents regarding Residents #6 and #7 were investigated, and he stated, No.</p> <p>During an interview on 6/12/2024 at 4:16 PM, the Activities Director stated, .I've been having issues with [Named Resident #10] for over a year now. [Named Resident #10] places his hands wherever he can on female residents such as hands, legs, and thighs. Then tells them you know you want it. I've witnessed those incidents during activities. Female residents are afraid of him. I reported everything that occurred to the Administrator and DON. I was told that as long as he doesn't hurt anyone there's nothing they can do. I tried to put a seating chart in place so that [Named Resident #10] wasn't close to the female residents, but he [Resident #10] didn't like or agree with that .I witnessed [Named Resident #10] putting his hand on and rubbing [Named Resident #7]'s knee. I kept a log of the incidents involving [Named Resident #10] and gave it to the DON in a folder. [Named Resident #10] knows that it is wrong. I was told by the Administrator that I can't ask him to leave activities because he has a right to be there. It was also reported to me by [Named Resident #18] that [Named Resident #10] came into her room and demanded he kiss her. [Named Resident #10] has threatened to burn the building down and was looking for matches, and nothing was done. The Administrator and DON are well aware of the issues with [Named Resident #10] .</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Some</p>	<p>During an interview on 6/13/2024 at 10:50 AM, the Social Services Director (SSD) stated, .I have had concerns brought to me regarding [Named Resident #10] about the things he says and does. [Named Resident #10] came to me about not liking assigned seating, and I told him [Named Resident #10] that no one could keep him from activities .</p> <p>During an interview on 6/13/2024 at 1:00 PM, the DON stated, .[Named Administrator] is the abuse coordinator. I would consider a resident attempting to kiss another resident without permission sexual abuse. [Named Resident #10] was sent out last night [6/12/2024] to the hospital for psychological evaluation due to behaviors . The DON was asked what type of behavior was Resident #10 sent out for. The DON responded, . I believe it was for attempting to kiss another resident . The DON was asked when did the incident occur involving the kiss. The DON stated the day before [6/11/2024]. The DON was asked if she had been given a folder by the Activities Director regarding all the incidents and behavior involving Resident #10. The DON stated, .I will go look for it in my office .</p> <p>During an interview on 6/14/2024 at 2:00 PM, the DON stated that she could not find the folder that was given to her by the Activities Director documenting the incidents and behaviors of Resident #10 during activities.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to assure that a resident received an accurate assessment by staff qualified to assess relevant care areas for 1 of 1 (Resident #15) sampled residents reviewed.</p> <p>The findings include:</p> <p>Review of the Resident Assessment Instrument (RAI) (a means of ensuring that residents receive the highest quality of care and can maintain the highest quality of life) dated 10/2023, revealed .Intent: The intent of this section is to record the frequency that the resident was restrained by any of the listed devices or an alarm was used, at any time during the day or night, during the 7- day look-back period. Assessors will evaluate whether or not a device meets the definition of a physical restraint or an alarm and code only the devices that meet the definitions in the appropriate categories .Proper interpretation of the physical restraint definition is necessary to understand if nursing homes are accurately assessing manual methods or physical or mechanical devices, materials or equipment as physical restraints and meeting the federal requirements for restraint use .The regulation specifically states, 'The resident has the right to be free from any physical or chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms' (42 CFR 483.10(e)(1) and 483.12) .Prior to using any physical restraint, the nursing home must assess the resident to properly identify the resident's needs and the medical symptom(s) that the restraint is being employed to address. If a physical restraint is needed to treat the resident's medical symptom(s), the nursing home is responsible for assessing the appropriateness of that restraint .Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored . When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected .Steps for Assessment 1. Review the resident's medical record (e.g., physician orders, nurses' notes, nursing assistant documentation) to determine if physical restraints were used during the 7-day look-back period .2. Consult the nursing staff to determine the resident's cognitive and physical status/limitations .3. observe the resident to determine the effect the restraint has on the resident's normal function .4.Evaluate whether the resident can easily and voluntarily remove any manual method or physical or mechanical device, material, or equipment attached or adjacent to their body .5. Any manual method or physical or mechanical device, material or equipment should be classified as a restraint only when it meets the criteria of the physical restraint definition .6. Determine if the manual method or physical or mechanical device, material, or equipment meets the definition of a physical restraint as clarified .After determining whether or not an item listed in (P0100) is a physical restraint and was used during the 7-day look-back period, code the frequency of use .</p> <p>The facility uses the RAI manual in the place of a MDS policy.</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, and Seizures.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Waters of Smyrna, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Enon Springs Road East Smyrna, TN 37167	
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)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment.</p> <p>Review of the Quarterly MDS dated [DATE] revealed Resident #15 had a BIMS score of 2 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 was not coded for a restraint.</p> <p>Review of the Care plan dated 12/5/2024, revealed, .Interventions .1/13/2024 Have resident up in [Named chair] with activity table when awake near nurses [nurses'] station for closer observation .</p> <p>The care plan does not reflect the use of the physical restraint, the medical condition for the use, or when the restraint will be released as noted per the facility policy.</p> <p>Observation on 100/200 hall at the nurse's station on 6/11/2024 at 9:50 AM, 10:46 AM, 12:22 PM, 2:10 PM, 2:20 PM, 3:00 PM, 4:04 PM, and 4:45 PM revealed Resident #15 was sitting in a geriatric chair (a large padded supportive recliner that can be placed in upright position or reclined) with a connected tray across her.</p> <p>Observation at the 100/200 hall nurses' station on 6/12/2024 at 11:18 AM, revealed Resident #15 was sitting in the hallway in a geriatric chair with a tray across her.</p> <p>Resident #15 was unable to release the table tray and get up out of the geriatric chair without assistance.</p> <p>During an interview on 6/11/2024 at 4:20 PM, the MDS Coordinator stated Resident #15 received the geriatric chair a week after she came to the facility. The MDS Coordinator was asked what were the risk factors when placing Resident #15 in a geriatric chair with a tray secured over her. The MDS Coordinator stated, .it could be considered a restraint . The MDS Coordinator stated no one documented the tray had been released and had never known of her (Resident #15) asking to remove the tray. Continued interview revealed the facility had not completed a device assessment.</p> <p>During an interview on 6/12/2024 at 7:52 AM, the Director of Nursing (DON) was asked if the facility could physically restrain a resident at the family's request. The DON stated, No. The DON was then asked the medical symptom for the physical restraint. The DON stated Resident #15 had the geriatric chair for previous falls and behaviors upon admission. The DON was asked what the benefits of the physical restraint are. The DON stated it was for keeping Resident #15 safe and prevent falls. Further interview revealed the DON was unable to provide a physician's order, any assessments, consent for the use, or documentation of removal and timing of the release for the physical restraint.</p> <p>During an interview on 6/13/2024 at 10:10 AM, the MDS Coordinator was asked why the Quarterly MDS does not reflect the use of a chair that prevented Resident #15 from rising. The MDS Coordinator stated, . well she didn't have the tray on all the time .</p> <p>During an interview on 6/21/2024 at 1:15 PM, the MDS Coordinator stated she could not find any documentation related to an assessment, physician's order, or monitoring of the table tray connected to the geriatric chair of Resident #15. When asked if she went out to do the assessment of the restraint, the MDS Coordinator stated, I do not go out myself to do the assessment, I go by what is charted.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 6/21/2024 at 4:05 PM, the Regional [NAME] President (RVP) Clinical Services stated the facility did not have a MDS policy and the coordinator should follow the RAI manual for the MDS.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to implement a comprehensive person-centered care plan with appropriate interventions for 5 of 6 (Residents #6, #7, #10, #15, and #18) sampled residents reviewed.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, revised 3/21/2021, revealed .The Comprehensive Care Plan will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues .</p> <p>Review of the facility policy titled, Guidelines for Physical Restraints/Seclusion, dated 5/17/2023, revealed, . The care plan must reflect the use of the physical restraint-to include medical conditions as well as releasing at least q 2 hours-and skin checks during use at time of application and removal-with nurse to assess skin as indicated .</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Spastic Quadriplegia Cerebral Palsy, Bipolar Disorder, Aphasia, Anxiety Disorder, and Depression.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #6 revealed a Brief Interview of Mental Status (BIMS) score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 4/17/2024 for Resident #6 revealed no interventions were added to address sexual abuse when Resident #10 touched Resident #6's hair and rubbed her thigh without permission.</p> <p>During an interview on 6/12/2024 at 8:02 AM, Resident #6 stated she had issues with [Named Resident #10]. [Named Resident #10] keeps rubbing her leg. [Named Resident #10] reaches toward her to hold her hands. She stated she would tell him to stop, but he doesn't and just laughs. She stated she doesn't want another man touching her. He does it to other women. She stated that she reported the incidents to the Administrator and DON, and they told her they were going to handle it by getting [Named Resident #10] transferred. The first incident occurred last summer around June [2023] and continues to happen. Resident #6 stated she doesn't want to leave her room because [Named Resident #10] makes her feel uncomfortable, and she doesn't want to be around him. The Administrator and DON keep telling her they are working on doing something about the incidents. Resident #6 stated she doesn't want to keep talking about the incidents because she doesn't want to get kicked out the facility for seeming like she is causing problems due to reporting the incidents.</p> <p>Review of medical record revealed Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Polyneuropathy, Parkinson's Disease, Anxiety Disorder, and Dementia.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 11 which indicated moderate cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/2/2024 revealed no interventions were added to address sexual abuse when Resident #10 made nonconsensual sexual propositions with Resident #7, grabbed her hand, and rubbed her thighs.</p> <p>During an interview on 6/12/2024 at 7:52 AM, Resident #7 stated that she has had issues with [Named Resident #10]. Resident #7 stated that she doesn't remember the exact dates. Resident #6 stated [Named Resident #10] always reaches to hold her hand. She stated she would slap his hands away. Resident #7 stated that she reported the incident to the Administrator. Resident #7 stated she is unsure if they are doing anything about it. Resident #7 stated that [Resident #10] says the most inappropriate things sometimes, and that [Named Resident #10] makes her feel uncomfortable, and she doesn't want to be around him . Resident #7 was asked if she could share some of the comments Resident #10 had made. Resident #7 stated she would rather not go into detail about the comments. Resident #6 stated that [Named Resident #10] causes issues all the time during activities by trying to touch on other women and yelling at staff and other residents. Resident #7 stated that [Named Resident #6] is another woman here in the facility that Resident #10 has touched on.</p> <p>Review of medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due to Excess Calories, and Anxiety Disorder.</p> <p>Review of the Quarterly MDS dated [DATE] for Resident #10 revealed a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan for Resident #10 revealed, . [Named Resident #10] has an alteration in behaviors as evidenced by: yelling at staff and others at times. 4/19/23 [2023] verbally aggressive with others. 6/8/23 [2023] verbally loud and argumentative with staff and other residents. 2/8/24 [2024] verbally agitated with staff and residents. 2/21/24 [2024] throwing objects out of room into hallway, verbal threats. 3/17/24 [2024] cursing staff, throwing things in room, banging on his garbage can . Further review revealed no interventions for allegations of sexual abuse.</p> <p>During an interview on 6/13/2024 at 11:00 AM, Resident #10 stated, . I was sent out yesterday [6/12/2024] because I told [Named Resident #18] to give me a kiss on Tuesday [6/11/2024], and she told on me . Resident #10 was asked had he any issues before with residents. Resident #10 smirked and laughed, then stated, . I had a resident report that I was rubbing her hair .</p> <p>During an interview on 6/12/2024 at 11:06 AM, the Administrator stated [Named Resident #10]'s behaviors should be care planned.</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, and Seizures.</p> <p>Review of the Admission MDS dated [DATE] revealed Resident #15 had a BIMS score of 3 which indicated severe cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Quarterly MDS dated [DATE] revealed Resident #15 had a BIMS score of 2 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 was not coded for a physical restraint (table tray).</p> <p>Review of the care plan revealed, .Interventions .[1/13/2024] Have resident up in [Named chair] with activity table when awake near nurses [nurse's] station for closer observation .</p> <p>The care plan did not reflect the use of the physical restraint, the medical condition for the use or when the restraint will be released as noted per the facility policy.</p> <p>During an interview on 6/11/2024 at 4:20 PM, the MDS Coordinator stated Resident #15 received the geriatric chair a week after she admitted into the facility. Resident #15 was trying to get up and kept falling. The MDS Coordinator was asked what risk factors are present when placing a resident in a geriatric chair with a tray secured over the resident. The MDS Coordinator stated the tray could be considered a restraint.</p> <p>During an interview on 6/12/2024 at 7:52 AM, the Director of Nursing (DON) stated the family requested for the table tray for Resident #15. The DON was asked if the facility could physically restrain a resident at the family's request, she stated, No. The DON was asked the medical symptom for the physical restraint. The DON stated it was for previous falls and behaviors upon admission. The DON was asked what the benefits of the physical restraint are. The DON stated to keep the resident safe and prevent falls. The DON was unable to provide an order, any assessments, consent for the use, or documentation of removal and timing of the release for the physical restraint.</p> <p>During an interview on 6/13/2024 at 9:05 AM, the Physical Therapy Director stated, .today is the first time I have evaluated [Named Resident #15] for a sitting device .</p> <p>During an interview on 6/13/2024 at 10:10 AM, the MDS Coordinator was asked why the Quarterly MDS does not reflect the use of a chair that prevents rising. The MDS Coordinator stated she did not have the table tray on at all times. Further interview revealed the MDS Coordinator could not find any documentation related to an assessment, monitor for a table tray or a physician's order for the table tray connected to the geriatric chair. Further interview revealed, the MDS Coordinator admitted Resident #15 had the geriatric chair with the tray table since approximately one week after she admitted . When asked if she went out to do the assessment of the restraint, the MDS Coordinator stated, I do not go out myself to do the assessment, I go by what is charted.</p> <p>Observation on 100/200 hall at the nurse's station on 6/11/2024 at 9:50 AM, 10:46 AM, 12:22 PM, 2:10 PM, 2:20 PM, 3:00 PM, 4:04 PM, and 4:45 PM revealed Resident #15 was sitting in a geriatric chair (a large padded supportive recliner that can be placed in upright position or reclined) with a connected tray across her.</p> <p>Observation at the 100/200 nurses' station on 6/12/2024 at 11:18 AM, Resident #15 was sitting in her geriatric chair with tray across the resident.</p> <p>Review of the medial record revealed Resident #18 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Muscle Wasting and Atrophy Right Shoulder, Difficulty in Walking, and Muscle Wasting and Atrophy Left Shoulder.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Quarterly MDS dated [DATE] revealed Resident #18 had a BIMS score of 15 which indicated no cognitive impairment.</p> <p>Review of the Comprehensive Care Plan dated 5/14/2024 revealed no interventions were added to address allegations of sexual abuse when Resident #10 attempted to kiss Resident #18.</p> <p>During an interview on 6/12/2024 at 6:35 PM, Resident #18 stated, "[Named Resident #10] came into my room and demanded I give him a kiss. Then, he proceeded to come toward me. I yelled for him to get out my room. [Resident #10] looked at me and laughed then left out my room. I will fight him if he tries that again in order to protect myself. I notified the Administrator, DON, and Activities Director of the incident .</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to follow physician's orders and ensure that residents receive treatment and care in accordance with professional standards of practice for 1 of 3 (Resident #15) residents reviewed.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, GUIDELINES FOR PHYSICIAN ORDERS--(FOLLOWING PHYSICIAN ORDERS), dated 6/18/2023, revealed .Policy .It is the policy of the facility to follow the orders of the physician .Procedure .4) All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's dstay in the facility as the orders are received .</p> <p>Review of the facility's undated policy titled, Medication Administration, revealed .Purpose: To ensure that resident medications are administered in a timely manner and documentation is completed to substantiate administration .</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, and Seizures.</p> <p>Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 received an Antipsychotic [medication given for psychosis], Antianxiety [medication given for anxiety], Antidepressant [medication given for depression], and Opioid [medication given for severe pain] over the last 7 days.</p> <p>Review of the Quarterly MDS dated [DATE] revealed Resident #15 had a BIMS score of 2 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 received an Antipsychotic, Antianxiety, Antidepressant, and Opioid over the last 7 days.</p> <p>Review of the Medication Administration Record (MAR) dated 4/1/2024 - 4/30/2024 revealed an order for Lorazepam oral tablet 2 mg (milligram) give 1 tablet by mouth as needed for seizures, may give x 3 doses for seizure activity. Continued review of the MAR revealed Resident #15 received Lorazepam on 4/1/2024, 4/2/2024, 4/5/2024, 4/6/2024, 4/15/2024, and 4/19/2024.</p> <p>Review of the Progress Notes from 4/1/2024 to 4/30/2024 for Resident #15 revealed no documentation of seizure activity for the use of the Lorazepam.</p> <p>Review of the Progress Notes dated 4/4/2024 revealed, .resident observed anxious/restless in . chair in hall . resident unaware d/t current cognitive status .</p> <p>Review of the care plan dated 12/5/2023, revealed .Focus .Alteration in comfort related to .dx [diagnoses] includes seizures, anxiety .Focus .diagnosis of seizure disorder and is as [at] risk or [of] injury .Interventions . Observe for seizure activity .Staff to monitor for changes in level consciousness .Stay with resident if seizure activity occurs .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MAR dated 5/1/2024 - 5/31/2024 revealed an order for Lorazepam oral tablet 2 mg give 1 tablet by mouth as needed for seizures, may give x 3 doses for seizure activity. Continued review of the MAR revealed Resident #15 received Lorazepam on 5/23/2024, 5/25/2024, 5/29/2024, 5/30/2024, and 5/31/2024.</p> <p>Review of the Progress Notes from 5/1/2024 to 5/31/2024 for Resident #15 revealed no documentation of seizure activity for the use of the Lorazepam. Continued review of the Progress Notes revealed, .5/23/2024 13:43 [1:43 PM] .Medication Administration .Lorazepam Oral Tablet 2 MG Give 1 tablet by mouth as needed for seizures May give x 3 doses for seizures activity .Pt [Patient] agitated pulling on staff and chair .5/29/2024 12:13 [PM] .Medication Administration .Lorazepam Oral Tablet 2 MG Give 1 tablet by mouth as needed for seizures .Pt agitated and trying to get out of chair hollering at staff .5/31/2024 13:12 [1:12 PM] .Medication Administration .Lorazepam Oral Tablet 2 MG Give 1 tablet by mouth as needed for seizures May give x 3 doses for seizures May give x 3 doses for seizures activity .Pt restless and pulling at chair and calling out .</p> <p>Review of the Progress Notes from 5/1/2024 to 5/31/2024 revealed no documentation of seizure activity for the use of the Lorazepam.</p> <p>Review of the MAR dated 6/1/2024 - 6/12/2024 revealed an order for Lorazepam oral tablet 2 mg give 1 tablet by mouth as needed for seizures, may give x 3 doses for seizure activity. Continued review of the MAR revealed Resident #15 received Lorazepam on 6/3/2024, 6/5/2024, 6/7/2024, 6/9/2024, 6/11/2024, and 6/12/2024.</p> <p>Review of the Progress Notes revealed 6/3/2024, .Lorazepam Oral Tablet 2 MG .pt [patient] showing signs of anxiety [anxiety] .6/5/2024 .Lorazepam Oral Tablet 2 MG .Pt pulling at other Patients trying to get out of chair .6/7/2024 .Lorazepam Oral Table 2 MG . Resident anxious .</p> <p>Review of the care plan dated 12/5/2023, revealed .Focus .Alteration in comfort related to .dx [diagnoses] includes seizures, anxiety .diagnosis of seizure disorder and is as [at] risk or [of] injury .Interventions . Observe for seizure activity .Staff to monitor for changes in level consciousness .Stay with resident if seizure activity occurs .</p> <p>Review of the Progress Notes from 6/1/2024 to 6/12/2024 for Resident #15 revealed no documentation of seizure activity for the use of the Lorazepam.</p> <p>Review of the Progress Notes revealed 6/7/2024, .Lorazepam Oral Tablet 2 MG . Resident anxious . Continued review of the Progress Notes revealed on 6/9/2024, 6/11/2024, and 6/12/2024 Lorazepam was given, the Notes did not reveal any seizure activity.</p> <p>During a telephone interview on 6/14/2024 at 8:42 AM, Hospice Registered Nurse (RN) V stated, .I know of maybe 1 or 2 reported Seizures [Named Resident #15] has had .the Lorazepam order she has a standing order Hospice gives if a resident has a diagnosis of Seizures .it is a PRN [as needed] order and should only be given if the resident has a Seizure . The Hospice RN V was asked if she had any concerns with Resident #15's care at the facility. Hospice RN V stated, .Yes, inappropriate use of Lorazepam .I have educated the staff that the PRN Lorazepam is for Seizures .[Named Resident #15] will become anxious, and the facility has given her the Lorazepam .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a telephone interview on 6/18/2024 at 9:52 AM, Licensed Practical Nurse (LPN) JJJ was asked if she recalled giving Resident #15 Lorazepam. LPN JJJ stated, .It was change of shift .the nurse that gave me report said she [Resident #15] had been shaking a lot .I checked to see if she needed to go to the bathroom . took her [Resident #15] myself .put her back in the [named] geriatric chair .she became agitated .she began pulling away from the wall .increased agitation .I saw her behavior change .I gave the Ativan .she was shaking and coming out of the chair .I wasn't sure of the seizure protocol, so I gave it since she was shaking . she was care planned for behaviors .I did not call the MD .I wasn't sure of that protocol .I just knew it was given for seizures or agitation .</p> <p>During a telephone interview on 6/18/2024 at 10:07 AM, RN X was asked the reason for giving Resident #15 Ativan. RN X chuckled and replied, I gave it for agitation. That is the only time I would give this medication. When asked about the physician's order that read to give for seizure activity, RN X replied, [Named Resident #15] gets upset and her hands start shaking. That is the seizure activity, and that's when we give it. That's what hospice told me to do. I have learned since then; the activity usually happens when she needs to go to the bathroom. Now we do that first instead of giving the medicine right away. RN X was asked if the physician was notified if the resident was having seizure activity. RN X replied, No. I do not notify the physician about the seizures. Hospice said if we have to give her more than 2 or 3 doses a day, then we could give them a call.</p> <p>During a telephone interview on 6/18/2024 at 10:21 AM, the Pharmacist stated Resident #15 had an order for Lorazepam since 12/5/2023 and was prescribed by Hospice MD. When asked what the recommended mode of transmission for lorazepam would be related to seizures, the Pharmacist replied, .For seizures, generally it is injectable or cream. It would be hard to give a patient a PO [by mouth] lorazepam if they were having a seizure . The Pharmacist then stated the lorazepam 2 mg injectable would typically be available in the Cubex (a medication dispenser for controlled substances), however there was none available at that time per the Pharmacist.</p> <p>During a telephone interview on 6/18/2024 at 11:45 AM, the Hospice Medical Doctor [MD] stated she did order Lorazepam 2 mg for seizures but would be concerned if the nurses are not charting seizure activity when giving this medication. Continued interview revealed Resident #15 should have 3 active orders for Lorazepam. One for 2 mg for seizure activity, one for 2 mg for agitation, and one for 0.5 mg BID.</p> <p>During a telephone interview on 6/18/2024 at 2:50 PM, MD FF stated he signed off on some of the hospice orders. MD FF was asked if he felt lorazepam 2 mg PO was the correct mode of transmission for a resident with seizures. MD FF replied, .The lorazepam PO can be given after the seizure is over and not during the active phase . When asked if staff consistently charted 0 for a pain level, would prn pain meds need to be given. MD FF stated, If it consistently a 0, then no. However, if they are without the pain medication, the pain could come back and potentially become worse. The pain meds keep the patient comfortable.</p> <p>During a telephone interview on 6/20/2024, the facility Nurse Practitioner [NP] stated she was not notified about Resident #15's seizure activity, but the nurses would also call hospice for any concerns or request. When asked about giving Ativan 2 mg PO for seizures, the NP stated, Not for active seizures. It should be given IM in my professional opinion.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to provide sufficient staff to provide care and services in assisting residents to attain or maintain their highest practicable level of physical, mental, and psycho-social well-being for all residents at the facility.</p> <p>The findings include:</p> <p>Review of the facility policy titled, GUIDELINES STANDARD SUPERVISION, dated 5/17/2023, revealed, .6. Staff assignments are based on the resident needs as far as their acuity and their assessment results and their person-centered care planning. Therefore, the requirements of meeting those needs to include physical, emotional, psychosocial, social, and spiritual, will be accomplished by provision of as much hands on care as necessary. Further, supportive services to include staff from various departments in the facility and/or outside resources/vender services will be provided when indicated .</p> <p>Review of the Payroll Based Journal (PBJ) Staffing Data Report (A collection of data used to provide information on staffing levels) for 1/1/2023 to 3/31/2024, revealed, .Metric .One Star Staffing Rating .Result . Triggered .Definition .Triggered = Star Staffing Rating Equals 1 .Metric .Excessively Low Weekend Staffing . Result .Triggered .Definition .Triggered .Submitted Weekend Staffing data is excessively low . Continued review revealed, PBJ Staffing Data Report had triggered for Star Staffing Rating Equal 1 and Submitted Weekend Staffing data is excessively low for 1/1/2023 to 3/31/2023, 4/1/2023 to 6/30/2023, 7/1/2023 to 9/30/2023, and 10/1/2023 to 12/31/2023.</p> <p>Review of the FACILITY ASSESSMENT (designed for the facility to evaluate its resident population and identify the resources needed to provide the necessary services) dated 2/23/2024 revealed an average daily census between 72 and 80 residents. 95% - 100% of all residents required assistance with Activities of Daily Living (ADLs) with 1-2 person physical assistance.</p> <p>Review of the medical records revealed Resident #1 was admitted to the facility on [DATE], with readmission on 12/16/2021, with diagnoses which included Generalized Osteoarthritis, Dysphagia and Major Depressive Disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #1, revealed a Brief Interview for Mental Status (BIMS) score of 00, which indicated severe cognitive impairment. Continued review reveals Resident #1 required extensive assistance with bed mobility, transfers, locomotion on unit, dressing, eating, toilet use, and personal hygiene.</p> <p>Review of the care plan for Resident #1 revealed, . [6/2/2023] has potential for nutritional decline R/T [related to]: varied intakes, confusion/dementia, history of GI bleed .Requires extensive to total assist with meals .</p> <p>Review of the Nursing Home Licensure Checklist dated 6/11/2024, revealed a total of 2.58 Per Patient Day (PPD) for that day.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Daily Scheduled Nursing dated 6/11/2024, revealed four (4) nurses and thee (3) CNAs scheduled for the day.</p> <p>Observation throughout the facility on 6/11/2024 at 9:30 AM, revealed four (4) nurses and three (3) CNAs at the facility. The nurses were passing medications, and the three (3) CNAs were assisting residents with breakfast. Meal carts remained on the halls with untouched trays on them, waiting to be taken to assisted diners.</p> <p>During an interview on 6/12/2024 at 10:02 AM, family member (FM) L stated she had been to the facility several times and Resident #1's meal was on her bedside table with no one assisting her. The staff have not been taking the time to comb Resident #1's hair.</p> <p>Review of medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses which included Chronic Diastolic (Congestive) Heart Failure, Morbid (Severe) Obesity Due to Excess Calories, and Anxiety Disorder.</p> <p>Review of the Quarterly MDS dated [DATE] for Resident #10, revealed a BIMS score of 15, which indicated no cognitive impairment. Continued review revealed Resident #10 required extensive assistance with bed mobility, transfers, locomotion on and off unit, dressing, toilet use, and personal hygiene.</p> <p>During an interview on 6/13/2024 at 11:10 AM, Resident #10 stated the facility needed more staff and had waited up to 45 minutes for assistance. Resident #10 was asked how he knew it took up to 45 minutes to answer the call light. Resident #10 responded, I have four (4) phones and a clock. I know how long I have to wait.</p> <p>Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses which included Muscle Wasting and Atrophy, Multiple Sites, Type 2 Diabetes Mellitus without Complications, and Atherosclerotic Heart Disease of Native Coronary Artery.</p> <p>Review of the Admission MDS assessment dated [DATE] for Resident #12, revealed a BIMS score of 11, which indicated moderate cognitive impairment. Continued review revealed Resident #12 required the use of a walker, required partial/moderate assistance with oral hygiene, showers/bath, upper and lower body dressing and putting on and taking off shoes, requires supervision and touch assistance with personal hygiene and required set up assistance with eating.</p> <p>During an interview on 6/12/2024 at 11:09 AM, Resident #12 stated he hardly ever seen a Certified Nursing Assistant (CNA) and sometimes had to wait for his call light to be answered for 45 minutes to an hour. When asked how he knew it took that long to answer the call light, Resident #12 stated, I watch the clock and I have a phone.</p> <p>Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses which included Lack of Coordination, Urinary Tract Infection (UTI), and Muscle Wasting and Atrophy.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Admission MDS assessment dated [DATE] for Resident #13, revealed a BIMS score of 15, which indicated no cognitive impairment. Continued review revealed the use of a manual wheelchair, required set up assistance with eating, required partial/moderate assistance with upper/lower body dressing, shower/baths, putting on/taking off footwear, rolling left/right, sit to lying, lying to sit, sit to stand position changes, was frequently incontinent of bladder and always incontinent of bowel.</p> <p>During an interview on 6/12/2024 at 4:44 PM, FM III stated she had come into the facility several times and Resident #13 had been soaked with urine up to her shoulders. FM III stated Resident #13 would get changed between 8:00 PM and 10:00 PM but would not receive anymore care until the next morning. Continued interview revealed the weekend staff was low and the dining room was always closed.</p> <p>During an interview on 6/14/2024 at 1:12 PM, Resident #13 stated, .the facility is always short handed .I don't see anyone all night after they put me to bed .It does no good to put the light on because they will not come .I have to wait to be changed at night until right before the shift changes .sometimes it is only one person on this whole hallway .</p> <p>Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses which included Parkinson's disease, Anxiety disorder, Adult Failure to thrive, Contracture of Muscle, unspecified lower leg, and Contracture of Muscle, unspecified upper arm.</p> <p>Review of the Quarterly MDS dated [DATE], revealed Resident #17 had a staff interview for mental status which indicated poor short term and long-term memory. Continued review revealed Resident #17 was dependent for oral, personal and toileting hygiene, was dependent for shower/bathing, upper and lower body dressing, and putting on and taking off footwear, and partial/moderate assistance with eating.</p> <p>Review of the Care Plan for Resident #17 revealed, .[11/17/2022] Alteration in nutritional status .He is receiving a mechanically altered diet. He requires extensive assistance with his feeding .</p> <p>Observation on 6/12/2024 at 5:30 PM, Resident #17 was being fed by a CNA at the nurses' station close to the 200 Hallway.</p> <p>Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia and Hemiparesis, and Vascular Dementia.</p> <p>Review of the Quarterly MDS dated [DATE], revealed Resident #19 had a BIMS score of 1, which indicated sever cognitive abilities. Continued review revealed Resident #19 required the use of a wheelchair, required substantial/maximum assistance with eating and upper body dressing, and had been totally dependent with oral, toilet, and personal hygiene, dependence for shower/bath, lower body dressing, and putting on/taking off footwear.</p> <p>Review of the Care Plan for Resident #19 revealed, .[1/10/2022] at risk for Alteration in Nutritional Status .</p> <p>Observation on 6/12/2024 at 5:30 PM, Resident #19 was being fed by a CNA at the nurses' station close to the 200 Hallway.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure with Hypoxia, and Acute and Chronic Diastolic (Congestive) Heart Failure.</p> <p>Review of the Quarterly MDS assessment dated [DATE] for Resident #20, revealed a BIMS score of 12, which indicated moderate cognitive impairment.</p> <p>During an interview on 6/12/2024 at 8:25 AM, Resident #20 stated her call light was left on for an hour and a half. She stated staff would come in the room and say they would come back but did not. Resident #20 stated, If they tell me they will be back, I expect them to. When asked how Resident #20 knew that she waited for an hour and a half for staff to assist her, she replied, I looked at the clock on the wall and pointed to it. Continued interview revealed, Resident #20 stated the weekends were awful and very short staffed and had to wait for even longer periods of time when she called for assistance.</p> <p>Review of the medical record revealed Resident #21 was admitted to the facility on [DATE] with diagnoses which included Muscle Wasting and Atrophy, Multiple Sites, Type 2 Diabetes Mellitus with Hyperglycemia, and Dysphagia, Oropharyngeal Phase.</p> <p>Review of the Quarterly MDS assessment dated [DATE] for Resident #21, revealed a BIMS score of 4 which indicated severe cognitive impairment. Continued review revealed Resident #21 required the use of a wheelchair, required partial/moderate assistance with upper body dressing, substantial/maximal assistance with eating, oral hygiene, shower/bath, lower body dressing, dependent for toileting, putting on/taking off footwear and personal hygiene.</p> <p>Review of the Care Plan for Resident #21 revealed, [2/6/2023] Alteration in Nutritional Status as evidenced by: [named Resident #21] has a dx [diagnosis] pf CVA [Cerebral Vascular Accident], weakness, dysphagia [difficulty with swallowing]. She is on a modified diet with thickened liquids. Dx: Blind, feeding difficulties and requires assistance with meals .</p> <p>Observation on 6/13/2024 at 5:00 PM, Resident #17 was being fed by a CNA at the nurses' station close to the 200 Hallway.</p> <p>Observation of the facility on 6/11/2024 at 9:30 AM, revealed breakfast carts for all residents remained on the hallways. Residents remained in bed and were not being fed in a timely manner. Continued observation revealed three CNAs for 73 residents in the facility at that time.</p> <p>Observation on 6/11/2024 at 5:30 PM, revealed CNA F standing up, feeding a resident at the end of 100 Hall by the nurse's station.</p> <p>Observation of 200 Hallway on 6/12/2024 at 5:25 PM, revealed assisted diners being fed in the hallway by staff.</p> <p>During an interview on 6/12/2024 at 6:35 PM, CNA Z stated, .The dining room has always been closed for dinner since I been here. I believe it's due to not having enough staff in the building as the day progresses. The management staff is mostly gone so there isn't any extra help to be able to get residents to the dining room and assist with feeding .</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 6/12/2024 at 5:20 PM, CNA F stated she fed in the hallway so she could watch the fall risk patients. When asked if she thought feeding in the hallway was because of a staffing issue, CNA F replied, Yes, it would be.</p> <p>During an interview on 6/14/2024 at 8:45 AM, the Staffing Coordinator was asked how many CNAs were present on the morning of 6/11/2024, the Staffing Coordinator responded, .There were 3 CNAs here . When asked if 3 CNAs would be considered sufficient staff to meet the needs of the residents, the Staffing Coordinator stated, No.</p> <p>During an interview on 6/14/2024 at 11:05 AM, the Administrator was asked about the staffing needs at the facility. When asked how he thought breakfast went on the morning of 6/11/2023, the Administrator stated, I imagine breakfast was rough that morning.</p> <p>During an interview on 6/14/2024 at 11:33 AM, Licensed Practical Nurse (LPN) O stated there were only 3 CNAs in the facility on the morning of 6/11/2024. Continued interview revealed LPN O was asked what a reasonable time for a call light to be answered and she replied, A call light should be answered within 5 minutes.</p> <p>During a telephone interview on 6/18/2024 at 2:50 PM, CNA KK was asked if the night shift had ever worked short before. CNA KK replied, .We have worked with 3 people at night before . When asked if she felt this was enough staff to care for the residents at night, CNA KK replied, No. It makes it very hard to care for all the residents and their needs.</p> <p>During an interview on 6/21/2024 at 10:31 AM, CNA LL stated there were more call outs on the weekend, which made it hard to find staff to come in.</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>Based on facility policy review, medical record review, and interview, the facility failed to have sufficient staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being for 2 (Resident #1 and #15) of 7-sampled residents reviewed.</p> <p>The finding included:</p> <p>Review of the facility policy titled, Baseline Care Plan Assessment/Comprehensive Care Plans, dated [DATE], revealed, .The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum. The facility may need to review the care plans more often based on changes in the resident's condition and/or newly developed health/psycho-social issues .</p> <p>Review of the facility policy titled, Guidelines for Physical Restraints/Seclusion, dated [DATE], revealed, .It is the policy of the facility to use physical restraint only as a last resort and only after every other alternative to a physical restraint (based on assessment) that seemed to have the potential for being used successfully, has been tried, and has failed .A physical restraint is NEVER to be used for staff convenience or for discipline .The resident must have a complete order for the restraint which includes the type of restraint and when it is to be applied/released. The restraint order must include the related medical condition. All physical restraints are to [be] released and the resident is to be repositioned at least every 2 hours .If the resident cannot remove the physical restraint device on command-and using the proper technique for removal-the device is considered a physical restraint .Procedure .Complete the initial Physical Restraint Assessment . Review contributing factors such as behaviors/mood/fall risk/medical signs and symptoms/diagnosis/cognition/communication and ADL performance abilities .IDT to evaluate alternatives to physical restraint use and least restrictive interventions for the least amount of time .Explain and document the risk and benefits of treatment options related to physical restraints/devices to the resident as well as the representative/POA [Power of Attorney] .Obtain a detailed and specific doctor's order for the physical restraint/device which includes the specific physical restraint/device as well as when it is to be applied and released .Complete a new Physical Restraint/Device Assessment at least quarterly or if there is a change in the resident's condition (or if the medical condition for which the physical restraint is being used changes) to see if a lesser restraint can be used .The care plan must reflect the use of the physical restraint-to include medical conditions as well as releasing at least q 2 hours-and skin checks during use at time of application and removal-with nurse to assess skin as indicated .</p> <p>Review of the facility policy titled, GUIDELINES FOR PHYSICIAN ORDERS-(FOLLOWING PHYSICIAN ORDERS), dated [DATE], revealed, .Policy: It is the policy of the facility to follow the orders of the physician . The facility will have orders to provide essential care to the resident, consistent with the resident's mental and physical status upon admission .Procedure: 1) c. Routine care to maintain or improve the resident's functional abilities until staff can conduct a comprehensive assessment and develop an interdisciplinary care plan .2) As assessments are completed, orders will be received from the physician to address significant findings of the assessment .4) All physician orders received pertaining to the resident will be implemented and followed throughout the course of the resident's stay in the facility as the orders are received .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Job Description for the Administrator dated [DATE], revealed .reporting to the Governing Body, the Administrator leads and directs the overall operations of the facility in accordance with resident needs, government regulations and company policies so as to maintain quality care for the residents while achieving the facility's business objectives. There are multiple role responsibilities such as: working with management while doing planning for facility operations, conducting rounds to ensure resident needs are being addressed, maintaining working knowledge to ensure compliance with all governmental regulations and company's Quality Assurance Standards and management of turn-over to ensure that adequate staffing through development of recruitment resources, training and education while addressing family and resident satisfaction. The Administrator should also have the ability to identify and respond appropriately to potential behavior outbursts and recognize, remove and/or report potential hazards .</p> <p>Review of the undated Job Description for Director of Nursing (DON) revealed he/she will be under the supervision of the Administrator.The DON has the authority, responsibility and accountability for the functions, activities, and training of the nursing services staff .In the absence of the Administrator, the DON assumes responsibility .Role Responsibilities .knowledge, skills and techniques necessary to care for residents .Ensures that a sufficient number of qualified supervisory and supportive nursing personnel are assigned for each unit/shift to meet the residents needs .makes rounds upon entering the building each day . review all Accidents and Incidents daily and develop an appropriate plan to prevent future accident and incidents .</p> <p>Review of the undated Job Description for Registered Nurse revealed, .POSITION SUMMARY: The Registered Nurse provides direct nursing care to the residents and supervises the day-to-day nursing activities performed by nursing assistants. The person holding this position is delegated the administrative authority, responsibility, and accountability for carrying out the assigned duties and responsibilities in accordance with, current existing federal and state regulations and established company policies and procedures to ensure that the highest degree of quality care is maintained at all times .Role Responsibilities . 3. Receives telephone orders from physicians and record on the Physicians' Order Form .Transcribes physician's orders to resident charts, cardex [Kardex], and medication cards, treatment/care plans, as required .5. Charts nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to the care .Drug Administration .1. Prepares and administers medications as ordered by the physician .8. Reviews medication cards for completeness of information, accuracy in the transcription of the physician's order .9. Notifies the attending physician of automatic stop orders prior to the last dosage being administered .</p> <p>Review of the medical records revealed Resident #1 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses which included Generalized Osteoarthritis, Dysphagia and Major Depressive Disorder. Continued review revealed Resident #1 was a full code status.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 revealed, a BIMS score of 00 which indicated a severe cognitive impairment.</p> <p>Review of Care Plan for Resident #1 revealed, a care plan with goals and interventions that included Advanced Directives .Full Code status on file .</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Progress Notes dated [DATE] at 1:30 PM, the DON documented don notified of resident expiring. call made to daughter to notify her. daughter upset with information given. daughter states that she will be here to see her mother soon. awaiting daughter's arrival for funeral arrangements</p> <p>There was no documentation that the physician had been contacted.</p> <p>During a phone interview on [DATE] at 10:08 AM, FM L was asked when she had been contacted by the facility on [DATE] and she stated she received a call when her (Resident #1) had passed and said that she had not been updated concerning her condition prior to her death on that day.</p> <p>During a phone interview on [DATE] at 12:24 PM, MD HH was asked whether she had received a call regarding a change in Resident #1's condition. After MD HH reviewed her notes, there had been no documentation that the facility had contacted her on that day. MD HH reviewed her schedule and stated she had not rounded that day [[DATE]].</p> <p>During an interview on [DATE] at 12:35 PM, the Traveling DON for Named Consulting Company reviewed the Code Blue Record for Resident #1. The Traveling DON was asked what the expectation for the nursing staff was when a resident was observed with decreased heart rate and respiration, and no obtainable blood pressure and oxygen saturation. The Traveling DON responded, I would expect the nurse to get orders for oxygen, stay with the patient at the bedside and call 911. The physician should have been contacted immediately.</p> <p>During a phone interview on [DATE] at 1:04 PM, the DON stated if a resident had been found with vitals signs at the level noted in the Code Status form (Pulse of 38, ,d+[DATE] respirations per minute, and unattainable blood pressure and oxygen saturation), she would expect the crash cart to be gotten because a code blue would be imminent.</p> <p>Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease, Anxiety Disorder, and Seizures.</p> <p>Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #15 had a Brief Interview for Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 required substantial/maximal assistance to sit to stand, chair/bed to chair transfer, and partial/moderate assistance with walking 10 feet. Continued review of the MDS revealed Resident #15 received an Antipsychotic [medication given for psychosis], Antianxiety [medication given for anxiety], Antidepressant [medication given for depression], and Opioid [medication given for severe pain] over the last 7 days.</p> <p>Review of the Quarterly MDS dated [DATE] revealed Resident #15 had a BIMS score of 2 which indicated severe cognitive impairment. Continued review of the MDS revealed Resident #15 required substantial/maximal assistance to sit to stand, chair/bed to chair transfer, and walking 10 feet was not attempted due to medical conditions or safety concerns. Continued review of the MDS revealed Resident #15 received an Antipsychotic, Antianxiety, Antidepressant, and Opioid over the last 7 days.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/21/2024
NAME OF PROVIDER OR SUPPLIER The Waters of Smyrna, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Enon Springs Road East Smyrna, TN 37167	
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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During a telephone interview on [DATE] at 8:42 AM, Hospice Registered Nurse (RN) V stated she knew of maybe 1 or 2 reported Seizures [Named Resident #15] has had. The Lorazepam order was a standing order Hospice gave for a diagnosis of Seizures. The Lorazepam was a PRN [as needed] order that should have only been given if the resident had a Seizure. The Hospice RN V was asked if she had any concerns with Resident #15's care at the facility. Hospice RN V stated, .Yes, inappropriate use of Lorazepam . RN V stated she had educated the staff that the PRN Lorazepam was for Seizures. Resident #15 would become anxious, and the facility had given her the Lorazepam.</p> <p>During a telephone interview on [DATE] at 9:52 AM, LPN JJJ was asked if she recalled giving Resident #15 Lorazepam. LPN JJJ stated the previous nurse that gave me report said Resident #15 had been shaking a lot. Resident #15 had increased agitation, began puled away from the wall, was shaking, and coming out of the chair. RN V stated she saw Resident #15's behavior changes and she gave the Ativan because she knew it was given for seizures or agitation. RN V stated she was not sure of the seizure protocol, so she gave it [Lorazepam] since she was shaking. RN V stated Resident #15 was care planned for behaviors. Continued interview revealed, RN V did not call the MD and was not sure of that notification protocol.</p> <p>During a telephone interview on [DATE] at 10:07 AM, RN X was asked the reason for giving Resident #15 Ativan. RN X chuckled and replied, I gave it for agitation. That is the only time I would give this medication. When asked about the physician's order that read to give for seizure activity, RN X stated Resident #15 got upset, her hands start shaking, and that was the seizure activity, so we gave it. RN X stated hospice had told staff to do that. Continued interview revealed, RN X stated she had learned since then; the seizure-like activity usually happened when Resident #15 needed to go to the bathroom. Now, staff did that first instead of giving the medicine right away. Further interview revealed RN X was asked if the physician was notified if the resident was having seizure activity. RN X replied, No. I do not notify the physician about the seizures. Hospice said if we have to give her more than 2 or 3 doses a day, then we could give them a call.</p> <p>During a telephone interview on [DATE] at 10:21 AM, the Pharmacist stated Resident #15 had been prescribed Lorazepam 2 mg by the Hospice MD as of [DATE]. When asked what the recommended route for Lorazepam would be related to seizures, the Pharmacist stated it would be hard to give Lorazepam PO [by mouth] during an active seizure. The Pharmacist recommended Lorazepam as an injectable or a cream. Continued interview revealed, the Pharmacist then stated the lorazepam 2 mg injectable would typically be available in the Cubex (a medication dispenser for controlled substances), however there was none available at that time per the Pharmacist.</p> <p>Review of the Physician's Orders dated [DATE] to [DATE], revealed Resident #15 did not have an order for a geriatric chair with a table tray connected.</p> <p>Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #15 had a Brief Interview of Mental Status (BIMS) score of 2 which indicated severe cognitive impairment. Continued review revealed the MDS for Resident #15 was not coded for a restraint.</p> <p>Review of the care plan for Resident #15 dated [DATE], revealed no care plan for a restraint to the geriatric chair.</p> <p>Review of the Medication Administration Record (MAR) for Resident #15 dated [DATE] to [DATE], revealed no documentation of a physical restraint.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the Treatment Administration Record (TAR) for Resident #15 dated [DATE] to [DATE], revealed no documentation of a physical restraint.</p> <p>Review of the Weekly Wound Evaluation dated [DATE] revealed, a skin tear to the front of the right lower leg.</p> <p>Review of the TAR for Resident #15 dated [DATE] to [DATE], revealed no documentation of a physical restraint. Continued review revealed there was no documentation that treatments were performed daily on Resident #15's right leg skin tear.</p> <p>During an interview on [DATE] at 4:14 PM, Licensed Practical Nurse (LPN) O stated Resident #15 had the (named) geriatric chair since she had been working at the facility (7 months). LPN O stated Resident #15 could not remove the restraint from the geriatric chair and had never asked for it to be removed. LPN O stated Resident #15 would get angry and shake the table tray. Continued interview revealed LPN O could not find an assessment or an order for the geriatric chair or the table tray (restraint).</p> <p>During an interview on [DATE] at 4:20 PM, the MDS Coordinator stated, Resident #15 received the geriatric chair with a table tray about a week after she was admitted to the facility. When asked what risk factors were present when placing a resident in a geriatric chair with a tray secured over the resident, the MDS Coordinator stated it could be considered a restraint. Continued interview revealed the MDS Coordinator confirmed there was no documentation when the tray was released or a device assessment.</p> <p>Review of the medical record revealed no documentation of when the restraint was released.</p> <p>During an interview on [DATE] at 7:52 AM, the Director of Nursing (DON) stated, she could not verify staff had been trained related to the geriatric chair with a table tray. The DON stated the facility did not typically allow this type of chair, but the family had requested the geriatric chair with the table tray. The DON was asked if the facility could physically restrain a resident at the family's request and she stated, No. The DON was asked the medical symptom for the physical restraint. The DON stated Resident #15 had previous falls and behaviors upon admission. The DON stated the tray was not used as a restraint if it was used for activities. The DON was asked what the benefits of the physical restraint were. The DON stated the benefit was to keep Resident #15 safe and prevented falls. Continued interview revealed Resident #15 could not remove the table tray. Further interview revealed, the DON was unable to provide an order, any assessments, consent for the use, or documentation of removal and timing of the release for the physical restraint.</p> <p>During an interview on [DATE] at 8:15 AM, Registered Nurse (RN) X stated Resident #15 was unable to remove the tray and she was not aware of any documentation on the tray when it was released.</p> <p>During a telephone interview on [DATE] at 9:07 AM, Family Member (FM) Y stated the geriatric chair with the tray table was suggested to him by the DON. Further interview revealed FM Y did not know of any injuries Resident #15 had related to the chair.</p> <p>During an interview on [DATE] at 5:15 PM, LPN W stated Resident #15 could not remove the tray.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on [DATE] at 9:05 AM, the Physical Therapy Director stated that this day was the first time Resident #15 had ever been evaluated for a sitting device [Rocking recliner wheelchair that can tilt back 30 degrees].</p> <p>During an interview on [DATE] at 10:10 AM, the MDS Coordinator stated the Quarterly MDS did not reflect the use of a chair that prevented rising because Resident #15 did not have the tray in front of her at all times.</p> <p>During a telephone interview on [DATE] at 11:46 PM, Nurse Practitioner (NP) was asked if a table tray could be considered a restraint. The NP stated if a resident had the mental capacity to remove the tray themselves, it could be placed in front of a resident. When asked if Resident #15 had the mental capacity to remove a tray table, the NP replied, No, Resident #15 does not have the mental capacity to remove a table tray.</p> <p>During an interview on [DATE] at 12:40 PM, the Wound Care Nurse (WCN) stated Resident #15 sustained a skin tear to the front of the right lower leg when she tried to get up from the geriatric chair with a table tray connected.</p> <p>During an interview on [DATE] at 1:15 PM, the MDS Coordinator confirmed she was unable to find any documentation related to an assessment, physician's order, or monitoring of the table tray connected to the geriatric chair of Resident #15.</p> <p>Observation at the ,d+[DATE] nurses' station on [DATE] at 2:10 PM, revealed Resident #15 was sitting in the geriatric chair pulling on the tray with both hands and raising her buttocks off the seat. The staff failed to respond to Resident #15 pulling on the tray table and raising her buttocks off the seat.</p> <p>Observation in the dining room on [DATE] at 3:00 PM, revealed Resident #15 was sitting in the geriatric chair with a tray table across the resident during a movie. Resident #15 was observed pulling on the tray and lifting her buttocks off of the seat. No staff responded to the Resident #15.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831</p> <p>47127</p> <p>Based on facility policy review, temperature log review, observation, and interview, the facility failed to minimize the potential for foodborne illness transmission by not properly cleaning and sanitizing the inner components of the ice machine for 73 of 73 residents. The facility failed to document refrigerator temperatures to ensure the food was kept at a safe level for 3 of 3 nourishment room refrigerators which has the potential to effect all residents. The facility failed to ensure that food was not left in the refrigerator beyond safe to use by dates in all Nourishment Room Refrigerators.</p> <p>The findings included:</p> <p>Review of the undated policy titled Physical Plant-Daily Inspection, revealed, .Refrigerators .Inspect .check for cleanliness and clean if needed and check for proper operation .Ensure a working thermometer is present inside the unit and temperature is taken daily .</p> <p>Review of the policy titled Food Brought into The Facility by Friends/Family/Others [Outside Sources] For Resident Policy, dated 11/28/2016, revealed, .Food/beverages brought in may be stored in the resident ' s personal refrigerator or in the facility ' s appropriate pantry or refrigerator freezer .Foods/beverages that are in the original manufacturer's container when brought in will be labeled appropriately, but will be discarded after the expiration date .Cooked and [prepared foods brought in for resident will .be appropriately labeled and dated when accepted for storage and discarded after 48 hours .All refrigerators in use in the facility have an internal thermometer to monitor temperature .All refrigerators have their internal temps recoded daily .</p> <p>Review of the undated policy titled Ice Machine Preventative Maintenance, revealed .the facility should be checked for proper ice level, if not at satisfactory level, check equipment operation. The facility should also look for any calcium, lime, or algae. Check to ensure it is in a clean and sanitized state. This includes all ice machines throughout the facility including Dietary .</p> <p>Review of (Named Dietetic Solutions) Nutritional Services/Operations Policy Use By Guidelines dated 6/12/2023, revealed, .Foods with a manufacturer's use by date will still require an opened on date once the item is opened . [Named nutritional supplement] opened and refrigerated should be discarded after 4 days and thickened liquid, opened should be refrigerated for no more than 7 days.</p> <p>Observation on 6/11/2024 at 12:14 PM, in the 400 Hall nourishment room, revealed a large bottle of mustard, 2 bottles of mayonnaise, and 1 bottle of ketchup, and 1 bottle of salad dressing were in the refrigerator with no resident name and no open date present. There were 2 open jars of Pure Cranberry juice labeled room [ROOM NUMBER] with no open date present and an opened container of thickened fruit punch with delivery date of 5/7/2024 but no open date or discard by date present. There were 2 unlabeled and undated partially eaten frozen ice cream items in the freezer. The refrigerator temperature log was labeled May 2024 and had two temperatures documented on the 13th and 14th and the remaining dates had no temperatures documented.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Observation of the nourishment room between 100 and 200 Hall on 6/11/2024 at 12:20 PM, revealed a bottle of pineapple juice with no open date, an opened container of thickened fruit punch with delivery date of 5/7/2024 and no open/use by date, a bottle of apple juice and thickened tea, both with delivery dates of 4/2/2024 and no open/use by date present, and a container of [Named nutritional supplement] Vanilla Shake with delivery date of 4/30/2024, with no open/use by date present. There were multiple food items in plastic grocery bags with no label, no date and a bag of potatoes with no label and no date.</p> <p>Observation on 6/11/2024, in the 200 Hall nourishment room at 12:35 PM, revealed a container of [Named nutritional supplement] vanilla shake with delivery date of 4/30/2024 and opened Thickened Sweetened Tea with delivery date of 4/2/2024 with no open date. The refrigerator temperature log labeled May 2024 had 1 temperature recorded and 30 days with no temperature recorded.</p> <p>Observation and interview on 6/11/2024 at 1:35 PM, during a walking round with the Dietary Manager (DM), revealed outdated items were identified in 3 of the 3 nourishment rooms which included [Named nutritional supplement], thickened sweet tea, and fruit juice. The Dietary Manager stated those items should not have remained in the refrigerator. The ice machine in the 400 Hall nourishment room contained pink colored debris on the white surface inside the ice machine and this was confirmed present by the DM.</p> <p>Observation and interview on 6/11/2024 at 1:42 PM, was conducted in the Nourishment Room on the 400 Hall with the Director of Nursing (DON). The DON confirmed the debris in the ice machine and stated it should not have been there.</p> <p>Observation and interview on 6/11/2024 at 2:05 PM, revealed the Administrator was present in the 400 Hall nourishment room and the Maintenance Director walked in as well. The Administrator instructed the Maintenance Director to take the ice machine out of service.</p> <p>Observation on 6/14/2024 at 11:10 AM, revealed the refrigerator in the 200 Hall Nourishment Room had an open container of nutritional supplement with delivery date of 4/2/2024, with no open or use by date, and continued to have brown debris in the bottom of the refrigerator.</p> <p>Observation on 6/17/2024 at 10:25 AM, in the nourishment room located between the 100 and 200 Hall, revealed there was an open container of thickened sweet tea with delivery date of 6/2/2024 that had no open date and no use by date.</p> <p>Observation on 6/17/2024 at 10:30 AM, in the nourishment room behind the 200 Hall desk, revealed the brown debris continued to be at the bottom of the refrigerator.</p> <p>Observation on 6/17/2024 at 10:35 AM, revealed in the 400 Hall refrigerator there continued to be 4 opened condiment bottles with no label and no open or use by date on them. The ice scoop was observed in the ice chest.</p> <p>Observation on 6/17/2024 at 11:00 AM, revealed the refrigerator in the 200 Hall Nourishment Room remained soiled with the brown debris at the bottom under the drawers and had not been cleaned.</p>		