STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445503	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry County Nursing Home	127 E Brooklyn Avenue Linden, TN 37096

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51293 Based on policy review, review of meeting minutes, medical record review, and interview, the facility failed to ensure resident rights were reviewed during resident council meeting for 5 of 10 residents (Resident #10, #36, #38, #41, and #50) in attendance during resident council meeting. The findings include: 1. Review of the facility policy titled, Resident Rights, dated 9/2024, revealed The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . 2. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Anemia, Anxiety and Kidney Failure. Review of the MDS dated quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #10 was cognitively intact. 3. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE], with diagnoses including Parkinsonism, Dysphagia, Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #36 was cognitively intact. 4. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Anemia, Atrial Fibrillation, and Dysphagia. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #38 was cognitively intact. 5. Review of the medical record revealed Resident #41 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Heart Failure, and Depression. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #41 was cognitively intact. (continued on next page)

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

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Chronic Kidney Disease, Depression and Diabetes. Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #50 was cognitively intact. 7. Review of the Resident Council Minutes for August 2024 through November 2024, revealed no documentation that resident rights had been reviewed with residents in attendance. During an interview in Resident Council meeting on 12/11/2024 at 10:30 AM, Resident's #10, #36, #41, and #50 voiced concerns of staff not reviewing resident rights during the council meetings. During an interview on 12/11/2024 at 11:16 AM, the Activity Director confirmed Resident Rights are not reviewed during Resident Council Meetings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review, and interview, the facility failed to report an allegation of resident to resident abuse for 2 of 2 sampled residents (Resident #18 and #32) reviewed for abuse. The findings include: 1. Review of the facility's policy titled, Abuse, Neglect, and Exploitation, dated 1/20/2023, revealed .Each resident has the right to be free from abuse .Response and Reporting of Abuse .When abuse .is suspected . Contact the State Agency and the local Ombudsman office to report the alleged abuse .The Administrator should follow up with the government agencies .to confirm the report was received, and to report the results of the investigation when final . 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Alcoholic Cirrhosis, Depression, and Paranoid Schizophrenia. Review of the Care Plan dated 9/19/2023, revealed .potential for behavior problem r/t [related to] paranoid schizophrenia, hepatic encephalopathy, psychotropic medication, depression .Monitor behavior episodes . Document behavior and potential causes . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Basic Interview for Mental Status (BIMS) score of 10, which indicated Resident #18 was moderately cognitively impaired. 3. Review of the medical record revealed Resident #32 admitted to the facility on [DATE], with diagnoses including Parkinsonism, Anxiety, Diabetes, Depression, Schizoaffective Disorder, and Bipolar. Review of the annual MDS assessment dated [DATE], revealed Resident #32 has a BIMS score of 15, which indicated Resident #32 was cognitively intact. During an interview on 12/09/2024 at 10:16 AM, Resident #32 stated he went into the bathroom and Resident #18 followed him and began beating him on the head. Resident #32 confirmed he reported to a nurse but was unsure of the nurses' name. The Administrator was notified on 12/9/2024 at 4:59 PM by the survey team of the allegation of resident to resident altercation that occurred on 11/26/2024 between Resident #18 and Resident #32. The Administrator confirmed the date of the incident was on 11/26/2024. During an interview on 12/11/2024 at 12:36 PM, the Administer was asked the status of the investigation for the resident to resident altercation between Resident #18 and Resident #32. The Administrator stated, . talked to [Resident #32] .asked if there was any physical contact and he [Resident #32] said no . The Administrator confirmed he had not spoken with the nurse assigned to give care to Resident #32. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility was unable to provide documentation that the allegation of resident to resident altercation occurred on 11/26/2024 and was reported within 24 hours from the date of the alleged allegation. During interview on 12/11/2024 at 12:55 PM, Resident #32 confirmed to the Administrator and the Surveyor that Resident #18 hit him in the head several times. The facility failed to report the alleged resident to resident altercation between Resident #18 and #32 on 11/26/2024 and reported by Surveyors on 12/11/2024.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on policy review, medical record review, and interview, the facility failed to investigate an allegation of resident to resident abuse for 2 of 2 sampled residents (Resident #18 and #32) reviewed for abuse. The findings include: 1. Review of the facility policy titled, Abuse, Neglect, and Exploitation, dated 1/20/2023, revealed When suspicions of abuse .or reports of abuse .an investigation is immediately warranted .Components of an investigation may include .if the residents response is incongruent .interview the resident's family .gather how .the resident would react to the incident .Obtain witness statements, according to appropriate policies. All statements should be signed and dated .all alleged violations involving abuse .are reported immediately, but not more that 2 hours after the allegation is made .to the administrator of the facility and to other official (including the State Survey Agency) .Have evidence that all alleged violations are thoroughly investigated . 2. Review of the medical record revealed Resident #18 was admitted to the facility on [DATE], with diagnoses including Alcoholic Cirrhosis, Depression, and Paranoid Schizophrenia. Review of the Care Plan dated 9/19/2023, revealed .potential for behavior problem r/t [related to] Paranoid Schizophrenia, Hepatic Encephalopathy, psychotropic medication, Depression .Monitor behavior episodes . Document behavior and potential causes . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Basic Interview for Mental Status (BIMS) score of 10, which indicated Resident #18 was moderately cognitively impaired. 3. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE], with diagnoses including Parkinsonism, Anxiety, Diabetes, Depression, Schizoaffective Disorder, and Bipolar. Review of the annual MDS assessment dated [DATE], revealed Resident #32 had a BIMS score of 15, which indicated Resident #32 was cognitively intact. During an interview on 12/11/2024 at 3:30 PM the Administrator was asked when he was notified of the resident to resident altercation. He stated, Monday [12/9/2024]. When asked what the policy states about reporting he stated, .to do a report at the time we were notified . The facility investigation revealed the date of the incident was on 11/26/2024 and that a Certified Nursing Assistant (CNA) was aware of the resident to resident altercation and did not report the occurrence to the charge nurse or the abuse coordinator. The facility failed to investigate a resident to resident allegation of abuse timely and thoroughly.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on Center's for Medicare Services (CMS) Pressure Ulcer/Injury Coding Stages, policy review, medical record review, and interview, the facility failed to ensure staff failed to correctly identify and stage a pressure ulcer and failed to notify patient representative for changes for 1 of 3 (Resident #53) sampled residents reviewed for pressure ulcers. The findings include: 1. The CMS undated pocket guide for Pressure Ulcer / Injury Coding Stages, revealed .Stage 3 .Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon, or muscle is not exposed. Slough (dead tissue on the surface of the wound bed that prevents healing) may be present but does not obscure (prevent) the depth (deepness of the wound) of tissue loss .Pressure ulcer known but not stageable due to coverage of wound bed by slough and/or eschar . Unstageable pressure ulcers due to slough and/or eschar . Percentage of slough in a wound refers to the proportion of the wound bed that is covered by dead tissue [slough] .while the remaining .would be healthy granulation tissue .depth when referring to a wound means the deepest point of the wound .Stage 3 pressure injury always indicates depth in tissue loss, even if slough or eschar as long as the slough or eschar does not obscure the full extent of the tissue damage . 2. The facility's policy titled, Guidelines for Notifying Physicians/Family of Clinical Problems, dated 11/12/2024, revealed .These guidelines are to help ensure that .medical problems are communicated to the medical staff in a timely manner, efficient, and effective manner .all significant changes in resident status are assessed and documented in the medical record and family notified . 3. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Parkinson's Disease, Osteoarthritis, Dementia, and Hemiplegia/Hemiparesis. Review of a Weekly Pressure Injury Record dated 8/14/2024, revealed .Abrasion to R [Right] buttock showing decline now presenting as Stage 2 . Review of a Skin Wound Evaluation note dated 8/26/2024, revealed .Type .Pressure .Stage 3 .Location . Coccyx .Exact Date [date developed in the facility] .8/14/2024 .Wound Measurements .Area .0.7 cm [centimeters] x [sign for by] Length 0.9 cm x Width 1.0 cm .Depth 0.2 cm .Notifications .Resident / Responsible Party notified .BLANK . The facility failed to notify the responsible party on 8/26/2024, when the Stage 2 declined to a Stage 3 pressure ulcer. Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed Resident #53 was severely cognitively impaired and had 1 unhealed Stage 3 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin & Wound Evaluation sheet dated 9/11/2024, revealed .Pressure .Stage 3 .Location . Sacrum .Exact Date 8/14/2024 .Area .0.3cm x Length .0.8cm x Width .0.5cm .Depth .0.2cm .Granulation [healing tissue in the wound bed] .10% [sign for percent] .Progress .Deteriorating .Slough 90% wound filled . Notifications .Resident / Responsible Party Notified .[was blank and not completed] . Review of the Care Plan dated 9/18/2024, revealed .I have a potential for pressure ulcer development . Review of a Skin & Wound Evaluation sheet dated 9/18/2024, revealed .Pressure .Stage 3 Full Thickness Skin loss .Exact Date 8/14/2024 .Area .0.3cm x Length .0.8cm x Width .0.5cm .Depth [marked as Not Applicable] .Slough .100% of wound filled . Review of a Skin & Wound Evaluation sheet dated 9/25/2024, revealed .Pressure .Stage 3 .Sacrum .Exact Date .8/14/2024 .Area .0.5cm x Length .1.1cm x Width .0.6cm .Depth .Not Applicable [was not completed] . Slough .90% of wound bed filled . Review of a Skin & Wound Evaluation sheet dated 10/2/2024, revealed .Pressure .Stage 3 .Sacrum .Exact Date .8/14/2024 .Area .0.5cm x Length .0.8cm x Width .0.7cm .Depth [Not Applicable] Granulation .10% of wound filled .Slough .90% of wound filled . During an interview on 12/11/2024 at 2:02 PM, the Wound Nurse confirmed the resident had 90% slough in the wound bed and she was unable to see the wound bed to determine the depth with 90% slough. The Wound Nurse confirmed the family and physician should be notified of the wound changes. The Wound Nurse confirmed if the wound bed is not visible due to slough and unable to measure the depth then the wound would be Unstageable, and not a Stage 3. During an interview on 12/12/2024 at 1:39 PM, the Wound Nurse and the Wound Care Specialist confirmed that all wounds and pressure ulcers should be staged according to how they present, and their characteristics. The facility failed to properly identify the wound as an Unstageable due to 90% to 100% slough on the wound bed and the inability to see the wound bed to determine a depth, and failed to notify the physician and family representative when the wound started to decline in status.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on facility policy, medical record review, observation, and interview, the facility failed to ensure residents were free from accident hazards when sharps and hazardous personal items were found in 2 of 54 (Resident #19 and #56) resident occupied rooms and when in 1 of 3 (East Hall Shower Room) Shower Rooms was found unsecured and unattended with sharps and hazardous items. The findings include: 1. Review of the facility's policy titled, Care and Storage of Personal Care Items, dated 12/2024, revealed It is the policy of the facility to properly stored resident personal care items such as deodorant, shampoo, mouthwash, safety razors, fingernail clippers in a safe area to ensure safety .Resident mouthwash should be stored in a closed cabinet inside the resident room .Shampoo and bathing chemical should always be stored in a closed cabinet .If razors are used, discard in the sharps container or store in a locked cabinet . 2. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Spastic Hemiplegia, Tremors, and History Traumatic Brain Injury. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #19 had a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact, required moderate assistance from staff for Activities of Daily Living skills, and required maximal assistance for personal hygiene. Review of the Care Plan dated 9/18/2024, revealed .impaired cognitive function .right hemiplegia/hemiparesis r/t [related to] brain injury .I have tremors, alteration in neurological status r/t traumatic brain injury .I have contractures of RUE . Observation in Resident #19's room on 12/9/24 at 10:53 AM, and at 2:03 PM, revealed the following items in a plastic basket, sitting on a bedside table: a.1 (one) 18 oz (ounce) plastic container of mouthwash. b. A pair of silver nail clippers. c. 1 4 oz can of aerosol body spray. 3. Observation in the 100 hall room shower room on 12/9/24 at 11:15 AM, and at 1:55 PM, revealed the door to the shower room and the door to the storage cabinet in the shower room were opened, unlocked, and unsecured with the following items accessible: a. 1 opened pack of disposable razors containing #5 razors. b. 3 cans of aerosol spray deodorant. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. 3 cans of 1.5 oz can of shaving cream. d. 1 10 oz can of aerosol hair spray. e. 1 8 oz bottle of shampoo. f. 1 gallon plastic jug of shampoo body wash without a lid. During observation and interview on 12/9/24 at 11:20 AM, Licensed Practical Nurse (LPN) G confirmed the shower room and the cabinet inside of the shower room should not be left unlocked and unsecured. LPN G confirmed these items should be locked inside the cabinet and the shower room should be locked at all times. During an interview on 12/9/24 at 11:23 AM, the Maintenance Director confirmed the doors to the shower room and the cabinet inside the shower room should be locked at all times. 4. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, Heart Failure. Review of the annual MDS dated [DATE], revealed Resident #56 had a BIMS score of 7, indicating the resident was severely cognitively impaired, requiring moderate assistance of staff with Activities of Daily Living (ADLs) and was ambulatory. Observations in Resident #56's room on 12/9/2024 at 8:53 AM, 10:29 AM, and 1:32 PM, revealed a large 32-ounce bottle of mouthwash, approximately 80% full was on the bathroom sink. During an interview on 12/9/2024 at 10:45 AM, LPN H confirmed the mouthwash should not be left in Resident #56's room. During an interview on 12/9/2024 at 1:45 PM, LPN I was asked if the large bottle of mouthwash should be unattended and left in Resident #56's room. LPN I stated, .no it definitely should not . LPN I removed the large bottle of mouthwash. 5. During an interview on 12/09/24 at 3:47 PM, the Director of Nursing (DON) confirmed the doors to the shower rooms should be locked and secured. The DON confirmed that the cabinets in the shower rooms should be locked and secured if not in use while staff are in the shower room. The DON confirmed all sharps and hazardous items should not be left in residents' room unattended and unsecured. 38909 51365

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on medical record review, observation, and interview, the facility failed to provide care and services for residents with a percutaneous endoscopic gastrostomy (PEG) tube (tube inserted into the stomach to administer medications, supplements and liquid food) when staff failed to ensure the enteral feedings and the flush solutions were properly labeled for 2 of 2 (Resident #51 and #59) sampled residents reviewed for enteral feedings. The findings include: 1. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Dementia, Dysphagia, and Anorexia. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed no Brief Interview for Mental Status (BIMS) score but documented that her cognitive skills for daily decision making were severely impaired. Resident #51 was dependent on staff for all care and was coded for a Feeding Tube. Review of the annual MDS dated [DATE], revealed no Brief Interview for Mental Status (BIMS) score was assessed and Resident #59 was severely cognitively impaired, dependent on staff for Activities of Daily Living skills and the use of a Feeding Tube. Review of the Care Plan dated 9/23/2024, revealed .I have diagnosis of Anorexia .I have .swallowing issues . receives nutrition per peg .I require tube feeding r/t inadequate po [oral] intake and hx [history] of Weight Loss . Review of Physician's Orders dated 9/26/2024, revealed .every shift IsoSource [nutritional supplement administered through a PEG tube] 1.5 @ [symbol for at] 70 ml [milliliters]/cc [cubic centimeter] X [symbol for times] 16 hrs [hours] daily turn on @ 5pm and off @ 9am . Observation in the Resident's room on 12/9/2024 at 9:59 AM, revealed Resident #'51's enteral feeding bag used for the PEG was not labeled with a date, rate of delivery, or staff initials. Observation in the Resident's room on 12/9/2024 at 9:59 AM, revealed Resident #'51's enteral feeding bag and automatic flush water bag only had 12/9/24 written on them, and was not labeled with the rate for delivery or staff initials. During an interview on 12/09/24 at 3:47 PM, the Director of Nursing (DON) confirmed all enteral PEG feeding bags and automatic flush water bags should be labeled, signed, and dated. 3. Review of the medical record revealed Resident #59 was admitted to the facility on [DATE], with diagnoses including Senile Degeneration, Bipolar Disorder, Depression, Conduct Disorder, Autistic Disorder, and Dementia. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS dated [DATE], revealed no BIMS score was assessed, the resident was severely cognitively impaired, was dependent on staff for eating, with active diagnosis of Dysphagia (difficulty swallowing), and the use of a Feeding Tube. Review of the Care Plan dated 6/13/2024, revealed .I require tube feeding r/t [related to] Resisting eating, Swallowing problem, Weight Loss .Provide Formula Rate, Flushes as ordered per Physician . Review of a Physician's Order dated 8/1/2024, revealed, .Enteral Feed every shift auto flush [automatic flush] @ 50cc an hour x 22 hours daily .every shift 2 Cal @ 45cc/hr X 22 hours . Observation in Resident #59's room on 12/9/2024 at 10:03 AM, revealed the enteral feeding bag and the flush bag was not labeled with the Resident's name, date, time or staff initials. During an interview on 12/9/2024 at 10:16 AM, LPN J was asked if the enteral feeding and flush bag should be labeled. LPN J stated, yes Observation in Resident #59's room on 12/11/2024 at 8:30 AM, revealed the enteral feeding bag was not labeled with the date, time, name or staff initials. The automatic flush bag dated 12/11/2024, was not labeled with the start time, the resident's name, the infusion rate or staff initials. During an interview on 12/11/2024 at 8:49 AM, the DON was shown the enteral feeding bag and automatic flush bag and asked what staff should do when hanging an enteral feeding with automatic flush. The DON stated .They should put the resident's name, date, formula, and the time it was hung . The facility failed to ensure that the enteral feeding and automatic flush bags were labeled appropriately.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to follow physician orders for the use of oxygen and failed to ensure oxygen concentrators were clean for 2 of 2 (Resident #29 and #40) sampled residents reviewed for oxygen use. The findings include: 1. Review of the facility's policy Oxygen Administration dated 10/14/2024, revealed .Oxygen therapy is the administration of oxygen at concentrations greater than that in ambient air .with the intent of treating or preventing the symptoms and manifestations of hypoxia .Hypoxia means decreased perfusion of oxygen to the tissues .Oxygen is administered under orders of a physician .Staff shall document the initial ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy .Cleaning and care of equipment shall be in accordance with facility's policies for such equipment . 2. Medical record review revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Chronic Respiratory Failure, Asthma, Tracheostomy Status, and Congestive Heart Failure. Review of the Physician Orders dated 8/29/2024, revealed, .PROVIDE TRACH CARE Q [every] SHIFT .O2 [oxygen] 2L [liters] / [symbol for per] min [minute] BNC [by nasal cannula] as needed for SOB [Shortness of breath], Hypoxia [low levels of oxygen in the body's tissue] . Review of annual Minimum Data Set (MDS) dated [DATE], revealed Resident #29 has a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident was cognitively intact, dependent on staff for Activities of Daily Living Skills, and received oxygen therapy and tracheostomy care. Observation in Resident #29's room on 12/11/2024 at 3:15 PM, and on 12/12/2024 at 8:02 AM, revealed Resident #29 in his room, tracheostomy collar intact with oxygen patent and being administered per tracheostomy collar at 3L/min, and the oxygen concentrator with dust and white residue on the top, on the sides, and on the bottom of concentrator. During observation and interview in Resident #29's room on 12/12/2024 at 10:15 AM, the Director of Nursing (DON) confirmed the oxygen concentrator should be set at 2L/MIN. The DON was asked who is responsible for cleaning the oxygen concentrators and filters. The DON confirmed she was unsure whose responsibility it was to clean the oxygen concentrators and filters. 3. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE], with diagnoses including Pneumonia and Dependent on Supplemental Oxygen. Review of a Physician's Order dated 7/10/2024, revealed .2L [liters]/min BNC as needed for SOB [shortness of breath] .Hypoxia . Review of the quarterly MDS dated [DATE], revealed Resident #40 had a BIMS score of 11, which indicted the resident was moderately cognitive impaired and required the use of oxygen. (continued on next page)

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	445503	A. Building B. Wing	12/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perry County Nursing Home	127 E Brooklyn Avenue Linden, TN 37096

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation in the resident's room on 12/9/2024 at 10:00 AM, 2:14 PM, and at 4:15 PM, revealed Resident #40 sitting on the bedside with oxygen cannula in bilateral nostrils, oxygen concentrator on and set at 4L/minute BNC. Observation in the resident's room on 12/10/24 at 8:02 AM, and at 4:13 PM, revealed resident in bed with eyes closed, oxygen cannula in bilateral nostrils and oxygen concentrator set at 4L/min BNC. During observation and interview in Resident #40's room on 12/11/24 at 8:48 AM, Licensed Practical Nurse (LPN) G was shown the oxygen concentrator set at 4L/min BNC and confirmed Resident #40 should be receiving her oxygen at 2 L/min BNC, and that the concentrator setting was incorrect. During an interview on 12/12/24 at 3:49 PM, the DON confirmed that staff should follow physician orders for the use of oxygen. 38909

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909 Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored and secured when 1 of 3 (Licensed Practical Nurses (LPN) F) nurses observed during medication administration left medications unsecured and unattended and during a random observation medications were found unsecured and unattended in 1 of 54 (Resident #56) resident occupied bathrooms. The findings include: 1. Review of the facility policy titled, Medication Storage reviewed and revised on 10/2024, revealed .It is the policy of this facility to ensure all medications housed on our premises will be stored .according to manufacturer's recommendations and sufficient to ensure proper .segregation and security .all drugs and biologicals will be stored in locked compartments .medication carts, cabinets, drawers .medication rooms . During a medication pass, medications must be under direct observation of the person administering medications or locked in the medication storage area/cart . 2. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Depression, Obstructive Reflux Uropathy, Anxiety, and Venous Insufficiency, and Limitations of Activities. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #17 was assessed with a Brief Interview for Mental Status (BIMS)Score of 8, which indicated the resident had moderate cognitive impaired, and required moderate to maximal assistance for Activities of Daily Living skills. Review of the facility's Order Review History Report dated 12/1/2024 to 12/31/2024, revealed .SYSTANE BALANCE 0.6% [percent] EYE DR [DROP] Instill 1 drop in both eyes three times a day for dry eyes . Observation during medication administration on the [NAME] Hall on 12/11/2024 at 8:30 AM, revealed Licensed Practical Nurse (LPN) F, knocked and entered Resident #17's room to administer her eye drops, placed the eye drops on the over the bed table, exited the room and entered another room to obtain gloves. LPN F left the eye drops on the over the bed table unsecured and unattended. LPN F then reentered Resident #17's room and administered the eye drops. 3. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE], with diagnoses including Dementia, Depression, Heart Failure. Review of the annual MDS dated [DATE], revealed Resident #56 was assessed with a BIMS score of 7, indicating the resident was severely cognitive impaired. Review of Physician Order dated 10/22/2024, revealed .Antacid Oral Tablet Chewable [Calcium Carbonate antacid] give 2 tablets by mouth every 8 hours as needed for indigestion . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations in Resident #56's room on 12/9/2024 at 8:53 AM, 10:29 AM and 1:32 PM, revealed an open undated, unattended, and unsecured bottle of antacids on the bathroom sink. During an interview on 12/9/2024 at 10:45 AM, LPN H confirmed Resident #56 has confusion and cannot self-administer her medication. LPN H was asked if medication should be left in Resident #56's room. LPN H stated No. During an interview on 12/9/2024 at 1:45 PM, LPN I was asked if a bottle of medication should be left in Resident's #56's room. LPN I stated No. LPN I removed the bottle of medication from the bathroom sink. During an interview on 12/12/2024 at 3:30 PM, the Director of Nursing (DON) verified medications should not be left at resident's bedside unattended and unsecured. 47835

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48285 Based on observation, and interview, the facility failed to ensure food was properly stored under sanitary conditions. In the kitchen, the vent hood was observed soiled, and 3 of 3 (West Hall, North Hall, and East Hall) nutrition refrigerators contained dead pests, opened, undated, unlabeled, and expired food items, and no thermometer. The findings include: 1. Observation in the kitchen on [DATE] at 8:49 AM, revealed the following: a. a vent hood over the kitchen stove with dust and grease buildup. 2. Observation in the [NAME] hall nourishment refrigerator on [DATE] at 3:52 PM, revealed the following: a. dead gnats (tiny black pests) on the bottom of the refrigerator. b. 1 opened, undated bottle of ketchup. c. 1 opened, undated and unlabeled bottle ranch dressing. d. 1 undated and unlabeled red bowl with unidentified food item. e. 1 undated and unlabeled breakfast sandwich. f. 1 undated and unlabeled frozen dinner. g. 1 undated and unlabeled divided plate with food items. h. 1 expired Jell-O cup (gelatin cup) dated [DATE]. i. 1 opened, undated, unlabeled, expired pack of bologna dated [DATE]. 3. Observation in the North Hall nourishment refrigerator on [DATE] at 3:30 PM, revealed the following: a. 1 opened, undated, and expired container of cottage cheese dated [DATE]. b. 1 opened, undated, and unlabeled plastic bottle of water. 4. Observation in the East Hall nourishment refrigerator on [DATE] at 3:45 PM, revealed a. 1 unlabeled and undated plastic bag with grapes and a protein bar. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. no thermometer. c. 1 opened, undated, and unlabeled container of vanilla ice cream. d. 1 opened, undated, and unlabeled container of ice cream. 5. During an interview on [DATE] at 10:30 AM, the Certified Dietary Manager was unsure how often the vent hood is cleaned and who cleans it. During an interview on [DATE] at 3:50 pm, the Director of Nursing confirmed that no food items should be in the refrigerators unlabeled, undated, and expired and no pest should be found in the refrigerators.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 1 (Certified Nursing Assistant (CNA) C) staff members was observed administering perineal care without the use of Personal Protective Equipment (PPE), when 1 of 1 (CNA B) staff members walked down the hall adorned in PPE, and when 1 of 1 (Wound Nurse) staff members failed to use hand hygiene during wound care. The findings include: 1. The facility's policy titled, Hand Hygiene, dated 11/12/2024, revealed .Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors .Hand hygiene is a general term that applies to either handwashing or the use of an antiseptic hand rub, also known as alcohol-based hand rub .The use of gloves does not replace hand washing. Wash hands after removing gloves . 2. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE], with diagnoses including Depression, Obstructive Reflux Uropathy, Anxiety, Hypertension, Venous Insufficiency, Limitations of Activities, Intervertebral Disc Degeneration. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #17 was assessed with a brief Interview for Mental Status (BIMS) score of 8, indicating the resident was severely cognitively impaired, required staff assistance for Activities of Daily Living (ADLs), the use of an indwelling urinary catheter, and had an open lesion. Review of the Care Plan dated 10/10/2024 revealed, .Impaired Skin Integrity related to rash and nonspecific skin eruptions to my back and buttocks .I have an indwelling foley catheter [a tube inserted into the bladder to drain urine continuously] .I require Enhanced Barrier Precautions r/t [related to] Indwelling cath [catheter] & Wounds to L [Left] & [and] R [Right] buttocks . Observation in Resident #17's room on 12/9/2024 at 1:38 PM, revealed CNA C was administering perineal care without the use of PPE for the resident who has an open lesion on her left buttocks and who has an indwelling urinary catheter. Observation in Resident #17's room on 12/11/2024 at 9:35 AM, revealed CNA A and CNA B in the resident's room. CNA B exited the room donned in her PPE to retrieve a urinal to empty the resident's indwelling urinary catheter bag. CNA B returned to the room and removed her PPE. CNA A and CNA B assisted Resident #17 to her wheelchair. CNA A removed her PPE, both CNA A and CNA B exited the room to weigh Resident #17. Neither CNA A or CNA B washed or sanitized their hands after removing their PPE, nor prior to assisting the resident to be weighed. 3. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Parkinson's Disease, Osteoarthritis, Dementia, and Hemiplegia/Hemiparesis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set, dated dated dated [DATE], revealed Resident #53 was severely cognitive impaired, dependent on staff for all Activities of Daily Living skills, incontinent of both bowel and bladder, and had a Stage 3 pressure ulcer. Review of a Physician's Order dated 10/14/2024, revealed .Cleanse sacrum with normal saline, apply collagen particles, cover with dry dressing .until healed . Observation in Resident #53's room during wound care on 12/11/24 at 9:30 AM, revealed the Wound Nurse knocked and entered the resident's room, donned a clean pair of gloves and cleaned the over the bed table with a sani cloth bleach wipe, removed her gloves, entered the bathroom and washed her hands. The Wound Nurse then returned to the treatment cart, placed a barrier on the over the bed table that was in the doorway of Resident #53's room, and began to remove supplies for the administration of wound care for Resident #53. The Wound Nurse knocked on Resident #17's door, entered the resident's room, closed the door, pulled the privacy curtains, donned a clean pair of gloves, and adjusted the height of the resident's bed. The Wound Nurse assisted the resident onto her right side, removed her gloves, donned a clean pair of gloves and failed to wash or sanitize her hands after removing her gloves and before donning a clean pair of gloves. The Wound Nurse removed Resident #53's brief, removed her gloves and donned a clean pair of gloves, removed the old dressing to Resident #53's sacrum, removed her gloves and donned a clean pair of gloves and cleansed the Stage 3 Pressure Ulcer to Sacrum with normal saline soaked 4 x 4 moistened gauze, removed her gloves, donned a clean pair of gloves, applied collagen particles to wound bed, and covered with a border gauze. The Wound Nurse donned clean gloves, put on a clean brief, applied skin prep to the resident's left hip, removed her gloves, donned a clean pair of gloves, assisted the resident to her left side, applied skin prep to the resident's right hip, removed the resident's sock from her right foot and applied skin prep to the outer right foot, removed her gloves and donned clean gloves and reapplied the sock to the resident's right foot. The Wound Nurse removed the boot from Resident #53's left foot, removed her sock, applied skin prep to the left outer foot, replaced the sock and boot to the resident's left foot and repositioned the resident and removed her gloves and donned a clean pair of gloves. The Wound Nurse replaced the blanket back over Resident #53, adjusted the bed height, removed her gloves and donned a clean pair of gloves. The Wound Nurse then exited the room, walked down the hall and disposed of the trash bag and the biohazard bag, entered the bathroom and washed her hands. The Wound Nurse failed to perform hand hygiene each time between changing gloves. 4. During an interview on 12/11/24 at 2:16 PM, the Director of Nursing (DON) confirmed that staff should wash their hands or sanitize with alcohol-based hand gel after removing gloves and before donning a clean pair of gloves. The DON confirmed that staff should remove PPE before exiting the resident's room and should not wear PPE while walking down the hall. 47835 48285