STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445510	A. Building B. Wing	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing Home	878-880 West Main Street Pleasant Hill, TN 38578

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, document review, medical record review, observation, and interview, the facility failed to ensure medical information was not visible for 5 residents (Residents #1, #3, #4, #22, and #46) of 55 residents observed. The findings include: Review of the facility's policy titled, Promoting-Maintaining Resident Dignity, dated 8/21/2023, showed .All staff members are involved in providing care to residents to promote and maintain resident dignity .Maintain resident privacy . Review of a facility document titled, Uplands Village Skilled and Long-Term Care Admission Handbook, dated 10/1/2018, showed .Residents .To be treated with consideration, respect and full recognition of his/her dignity . Resident #1 was admitted to the facility on [DATE] with diagnoses including Cognitive Communication Deficit, Quadriplegia and Bed Confinement Status. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had moderate cognitive impairment and required extensive assistance of 2 staff for bed mobility, hygiene and dressing and total dependence on staff for toileting. During an observation on 2/12/2024 at 12:40 PM, Resident #1 was listening to the radio, and there was a sign on the closet door that stated, .[brand of adult briefs] briefs L [large]/XL [extra large] .[tick marks indicated soiled briefs] .Please turn in the sheets of those who discharge right away . The sign was visible to anyone entering the room. During an observation and interview on 2/12/2024 at 1:02 PM, Certified Nursing Assistant (CNA) #2 stated the sign on the closet door was an inventory sign where staff kept inventory of briefs and wipes in the room of each resident who used them. During a telephone interview on 2/13/2024 at 2:41 PM, Resident #1's mother stated she did not request the sign to be placed in the resident's room, and the facility did not ask permission to display the sign in the resident's room. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #3 was admitted to the facility on [DATE] with diagnoses including Hypertensive Heart Disease with Heart Failure, Anemia and Hypothyroidism. Review of the quarterly MDS assessment dated [DATE], showed Resident #3 was cognitively intact and required substantial assistance with toileting, showering and dressing. The resident was always incontinent of urine and occasionally incontinent of bowel. During an observation on 2/12/2024 at 1:23 PM, in Resident #3's room, a sign was observed on the closet door that stated the type and size of incontinent brief the resident wore. The sign stated .[brand of adult briefs] briefs L/XL .[tick marks indicated soiled briefs] .Please turn in the sheets of those who discharge right away . The sign was visible to anyone who entered the room. During an interview on 2/12/2024 at 1:30 PM, Resident #3 stated she didn't know why the sign was on her closet door. She stated she didn't ask the facility to put the sign up. Resident #4 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Essential Hypertension, Heart Failure and Chronic Atrial Fibrillation. Review of the quarterly MDS assessment dated [DATE], showed Resident #4 had severe cognitive impairment and required supervision with toilet transfers and tub/shower transfers. The resident was always incontinent of urine and occasionally incontinent of bowel. During an observation and interview on 2/12/2024 at 1:13 PM, in Resident #4's room, Licensed Practical Nurse (LPN) #2 observed a sign that stated, .[brand of adult briefs] briefs L/XL .[tick marks indicated soiled briefs] .Please turn in the sheets of those who discharge right away . The LPN stated .it is how the staff keeps track of inventory of residents' items . During a telephone interview on 2/13/2024 at 2:37 PM, Resident #4's Power of Attorney (POA) stated the facility was not asked to place the sign detailing briefs on the front of the closet door. Resident #22 was admitted to the facility with diagnoses including Diabetes Mellitus with Foot Ulcer, Essential Hypertension and Hypothyroidism. Review of the quarterly MDS assessment dated [DATE], showed Resident #3 had moderate cognitive impairment and required partial assistance with rolling left to right and lying to sitting on the side of the bed. The resident was occasionally incontinent of urine and bowel. During an observation and interview on 2/12/2024 at 12:25 PM, a sign hung on the resident's closet door that stated, .[brand of adult briefs] briefs L/XL .[tick marks indicated soiled briefs] .Please turn in the sheets of those who discharge right away . The sign was visible to anyone who entered the room. The resident stated she didn't know why that sign was there. During a telephone interview on 2/13/2024 at 2:20 PM, Resident #22's representative stated she did not ask the facility to place a sign regarding briefs in the resident's room. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 2/12/2024 at 3:19 PM, the Assistant Director of Nursing (ADON) observed the inventory signs in the rooms of Residents #1, #3, #4, #22. The ADON confirmed the signs were in each room, were visible to anyone walking into the room and were a dignity issue to each resident. She stated the signs were supposed to be taken down. 41782 Resident #46 was admitted to the facility on [DATE] with diagnoses including Respiratory Failure, Pneumonia, Pancytopenia (lower than normal red and white blood cells and platelets in the blood), Heart Failure, Acute Kidney Failure, and Muscle Weakness. Review of the admission MDS assessment dated [DATE], showed Resident #46 was cognitively intact. During an observation and interview on 2/12/2024 at 3:34 PM, there was a sign posted above Resident #46's bed that read, NO IM [intramuscular] or IV [intravenous] Sticks. The sign was visible to anyone that entered the room. The resident stated the sign was posted because .they can't get any more blood out of me . The resident denied requesting the sign to be posted and stated, .I guess one of the nurses put it up . During an observation on 2/13/2024 at 7:55 AM, there was a sign posted above Resident #46's bed that read, No IM or IV Sticks. The sign was visible to anyone that entered the room. Review of the medical record showed no evidence the sign had been requested by the resident or family. During an interview on 2/13/2024 at 2:19 PM, the Director of Nursing (DON) stated resident needs were to be communicated to staff members via the care plan and signage was not to be posted in resident rooms unless requested by the resident or family. During an observation and interview on 2/13/2024 at 2:21 PM, in Resident #46's room, the DON confirmed the sign was present above the resident's bed and was visible to anyone that entered the room. The DON confirmed the information from the sign should be communicated to staff members via the care plan. The DON stated she was unaware who had posted the sign. During an interview on 2/14/2024 at 3:37 PM, the DON confirmed there was no documentation in the medical record that Resident #46 or Resident #46's family requested the signage be posted.

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F 0689 Level of Harm - 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** 41782 Based on facility policy review, medical record review, observation and interview, the facility failed to prevent accidents related to falls for 1 resident (Resident #45) of 5 residents reviewed for falls when effective and appropriate interventions to prevent falls were not implemented which resulted in actual harm to Resident #45. The findings include: Review of the facility's policy titled, Accidents and Supervision, updated on 8/21/2023, showed .The resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes .Identifying hazards(s) and risk(s) . Implementing interventions to reduce hazard(s) and risk(s) .Monitoring effectiveness and modifying interventions when necessary .The facility shall establish and utilize a systematic approach to address resident risk .to minimize the likelihood of accidents .Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk .Implementation of Interventions .using specific interventions to try to reduce a resident's risks from hazards in the environment .Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents . Resident #45 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Encephalopathy (a brain disease that alters brain function), Subsequent Encounter for Fall, Dementia, Muscle Weakness, Abnormalities of Gait and Mobility, Difficulty in Walking, and Cognitive Communication Deficit. Review of the Admission assessment dated [DATE], showed Resident #45 had short and long term memory problems. Resident #45 had 3 or more falls in the last 3 months, required assistance for ambulation, had unstable balance, intermittent confusion, and gait problems while standing and while walking. The Resident's Fall Risk Assessment score was 20, which indicated the resident was at high risk for falls. Review of the care plan dated 1/6/2024, showed .Has risk factors for falls: Assistive Devices walker and wheelchair. Needs assist for transfer Limited assist of one. Poor safety awareness elder has memory issues . Assist w/ [with] transfers using assist as needed .Assist w/ambulation using assist as necessary to complete task safely. Ensure use of assistive device used for ambulation if necessary .Wheelchair for mobility thru home .Keep call light within reach; keep floors clean, dry and free of clutter; keep assistive devices within reach; keep personal articles used frequently within reach while in bed .provide adequate lighting; encourage wearing of non-skid shoes or slippers for all transfers/ambulation .Assess behavioral issues that place Elder at risk for fall/injury, cognitive deficits and accommodate forgetfulness regarding safety and environmental hazards .Redirect as needed to maintain safety. Accommodate routine or approaches to minimize safety risks .Fall at home. Need for skilled nursing monitoring .Refer to PT [physical therapy], OT [occupational therapy] .for evaluation and treatment for decline in ability . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed the resident had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #45 required a walker for mobility. The resident required partial/moderate assistance for walking, sit to stand, roll left and right, chair to bed/bed to chair transfers, sit to lying, toilet transfers, tub/shower transfers, and lying to sitting on the side of the bed. The resident was dependent on staff for picking up objects. The resident was always continent of urine and occasionally incontinent of bowel. Resident #45 had a fall prior to admission and had no falls since admission to the facility. The resident received speech therapy, occupational therapy and physical therapy. Review of the facility investigation documentation showed Resident #45 had an unwitnessed fall on 1/14/2024 at 6:15 PM, in her room. The resident was found on the right side of the bed in front of the recliner. It was noted .Resident stated that she was attempting to get out of her recliner, in order to close her blinds, scooted down the chair and slipped out of it, onto the floor. Declines hitting her head during incident .Nurse closed residents [resident's] blinds and reeducated resident on call light use, following that, nurse assisted into a lying position .Reminder signs, and Stop signs put up in view of patient .No Apparent Injury . Review of the care plan updated on 1/14/2024, showed .At risk for injurious falls related to weakness, unsteadiness, impaired balance .1/14/24 Keep call bell [call bell was an intervention on 1/6/2024], fluids, and personal items within [Resident #45's] reach [an intervention in place on 1/6/2024] .Put reminder signs in room. Resident states she sees them and understands .Reminder & [and] Stop signs placed withing [within] Elder's view to remind Elder to call for assistance when she needs help . Review of the care plan updated on 1/16/2024, showed Impaired Cognition .Related to Dementia .Orient as needed throughout conversation .Mobility, Impaired physical .Related To .frequent falls . Review of the Nursing Interdisciplinary Notes dated 1/22/2024, showed .Heard Call from housekeeping staff, elder noted to be on ground, fall suspected, not witnessed .small s/t [skin tear] noted to right elbow. no other . injury noted. elder wasn't using assistive device and encouraged to . Review of the facility's investigation documentation showed the resident had an unwitnessed fall on 1/22/2024 at 6:40 AM, in the hallway. It was noted .Location Specifics: front of nurse's station wellness 1 . Resident's Description: I don't know why I fell or why I'm here .elder assessed for injury, assisted to room . Contributing/Environmental Factors: Ambulation WITHOUT Gait Device . Review of the care plan updated on 1/22/2024, showed .1/22/24 Keep bed in lowest position at all times when not working at the bedside [the resident fell in the hallway and not from the bed]. Encourage resident to use her walker . Review of the Speech Therapy Treatment Encounter Note dated 1/25/2024, showed .SLP [Speech Language Pathologist] used principles of spaced retrieval to increase carryover for use of call button. Pt [patient] achieved 0% acc [augmentative and alternative communication] on this date. Re-education and repetition did not benefit .Pt achieved 0% acc for identification for reasons to use call button with education again not beneficial . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Interdisciplinary Notes dated 1/26/2024, showed .Elder found in floor at 0545 [5:45 AM]. No injuries/pain noted, no changes in LOC [level of consciousness]. When asked what elder was doing, stated 'trying to go to bathroom.' Elder stated she hit her head .Neuro checks initiated. Education provided to call for assistance for ambulation/transfers/toileting .[reminder signs to call for assistance were placed in the resident's sight on 1/14/2024 and resident was encouraged to use walker after 1/22/2024 fall] [Medical Director] notified at 0558 [5:58 AM] . Review of the facility's investigation documentation showed the resident had an unwitnessed fall on 1/26/2024 at 5:45 AM, in the resident's room. It was noted .elder found in floor next to heater, no injuries noted, skin check completed, no pain noted at this time .Resident's Description: 'I was trying to go to bathroom' elder stated 'I hit my head' .no pain noted .neuro checks initiated .doctor notified . Contributing/Environmental factors: Unassisted Ambulation . Review of the care plan updated on 1/26/2024, showed .1/26/24 Reminder to push call light [reminder signs placed within resident's sight on 1/14/2024] and Keep room well lit and clutter free [previous intervention dated 1/6/2024, no new intervention put into place]. Resident often prefers lights out . Review of the facility's fall investigation documentation showed the resident had an unwitnessed fall in the resident's room on 2/6/2024 at 12:30 AM, .Location Specifics: In front of the window .This nurse and CNA [Certified Nursing Assistant] on shift heard a single loud thud that came from this residents room. Staff entered residents room to find her on the floor sitting with her left arm supporting her and her right hand up to her nose. Nurse assessed resident and found superficial skin tear to midline nasal dorsum, as well as mild epistaxis [nosebleed] from left nostril. Light pressure applied to affected area. Nurse inquired with resident if she had hit her head during the incident, to which she confirmed that she did. Resident voiced c/o [complaints of] headache, and declined pain elsewhere. No other injuries were noted .Staff assisted resident to her feet, and transferred her to her bed in a seated position. CNA remained with resident, while this nurse began notifying appropriate personnel. @ [at] 0035 [12:35 AM] M.D. [Medical Doctor] ordered this resident to be sent to ER [emergency room] for further evaluation .Resident's Description: Resident stated that she was attempting to ambulate to the large chair next to the window, but lost her balance. She stated that she hit her head during the incident, and complained of headache like pain .Contributing/Environment factors: Lost Balance . Review of the hospital Emergency Documentation dated 2/6/2024, showed XXX[AGE] year-old FEMALE TO THE EMERGENCY DEPARTMENT BY AMBULANCE FROM NURSING HOME WITH REPORT OF FALL WITNESSED TONIGHT. fell FACE FORWARD. NO SPECIFIC PRECIPATING EVENT. ABRASION ON BRIDGE OF NOSE. HISTORY OF GAIT INSTABILITY AND FREQUENT FALLS .NO ACTIVE BLEEDING. NO OTHER ACUTE COMPLAINTS .PATIENT WITH HISTORY OF ADVANCED DEMENTIA .Physical Exam .Head .ABRASION TO NOSE .CT [Computed Tomography] Brain/Head .FINDINGS .IMPRESSION .No definite acute intracranial abnormality .No hemorrhage .Diagnosis: Abrasion of nose; Ground-level fall; Unsteady gait .CONTINUE ALL CURRENT MEDICATION. CONTINUE MEASURES TO PREVENT FUTURE FALLS . The resident was discharged back to the facility on [DATE] at 4:05 AM. Review of the care plan updated on 2/6/2024, showed .2/6/24 Personal alarm in place for safety. New clip alarm after 4th fall to assist staff in being able to respond to resident quicker. Previous attempt for caution signs unsuccessful . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the advanced practice nurse's Progress Note dated 2/6/2024, showed .Chief Complaint/Nature of Presenting Problem: Follow-up falls with weakness .history of falls. Apparently she had a fall resulting in an ER visit. She was found to have an abrasion but no other acute injuries .continues to be weak and she is receiving skilled rehabilitation. On today's exam she denies pain .PHYSCIAL EXAM .Alert, NAD [No acute distress] .Generalized weakness. No evidence of pain with passive ROM [range of motion] .No neurological deficits noted .Awake alert confused to place and time .DIAGNOSIS, ASSESSMENT AND PLAN .History of fall .Facility protocol .Cognitive impairment .Chronic, continue provide supportive care .Generalized weakness .PT OT as recommended . Review of the Skin Evaluation Form dated 2/6/2024, showed .small skin tear to midline nasal dorsum following fall . During an observation and interview on 2/12/2024 at 12:46 PM, Resident #45 was seated in the recliner in her room. There was a walker at the bedside and the resident's bed had 1/4 bilateral upper siderails. The resident had an alarm on the chair and was wearing non-skid socks. The resident had a band aid over her nose. There were 2 signs posted on the closet door, the first sign read .Stop Ask for help . and the 2nd sign read, .Reminder Push your call light before trying to get up on your own . This surveyor asked the resident what the signs said and the resident verbalized that the signs were to remind her to call for help before getting up. During an observation on 2/13/2024 at 5:55 AM, Resident #45 was lying in bed sleeping. Resident #45 had 1/4 bilateral upper side rails up on bed, a walker at the bedside, and a bed alarm on. The bed was low and locked, call light was in reach, and reminder signs to call for help were posted on the resident's closet door. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview and review of facility documentation and Resident #45's medical record on 2/13/2024 at 10:33 AM, with the Director of Nursing (DON) revealed the resident had 4 falls while at the facility. The resident's admission falls risk assessment score was 20 which indicated the resident was at high risk for falls. Care planned interventions to prevent falls included assistance with transfers and ambulation, keeping call light, assistive devices and personal items within reach, adequate lighting, keep floor clean and clutter free, and non-skid footwear. Resident #45 had an unwitnessed fall in her room on 1/14/2024 at 6:15 PM. The resident was found in the floor in front of her recliner and said she was trying to close her blinds. The resident had no injury from the fall. The new intervention to prevent further falls was to put reminder signs up in her room. Resident #45 had an unwitnessed fall on 1/22/2024 and was found in the hallway on the floor by housekeeping. Resident #45 obtained a skin tear on her right elbow. The new intervention to prevent further falls was to encourage the resident to use her walker. Resident #45 had an unwitnessed fall on 1/26/2024 and was found in her room on the floor next to her heater. The resident said she was trying to go to the bathroom when she fell , and she hit her head. The resident had no injury from the 3rd fall. The new intervention to prevent further falls was to remind her to use the call light and keep her room well-lit and clutter free. Resident #45 had a diagnosis of dementia and a BIMS score of 3, indicating she was severely cognitively impaired. The DON confirmed the intervention to provide adequate lighting was already in place. The DON confirmed Resident #45 had dementia, poor cognition, and multiple falls so reminding the resident to use the call light was not an appropriate intervention to prevent further falls. The DON confirmed no new appropriate interventions were implemented after the resident's 3rd fall on 1/26/2024. Resident #45 had another unwitnessed fall on 2/6/2024 in her room. The resident stated she was going to the large chair next to the window and lost her balance. The resident stated she hit her head during the incident and complained of a headache. Resident #45 was sent to the ER for further evaluation. The DON stated .we were kind of at a loss for new interventions .we had exhausted everything we knew to do . During an interview on 2/14/2024 at 11:04 AM, Licensed Practical Nurse (LPN) #3 stated he was responsible for the resident when she sustained 2 of her falls. The LPN stated he was responsible for the resident when she fell on [DATE]. The LPN was seated at the nurse station and heard the resident call out for help. LPN #3 entered the room and saw Resident #45 seated on the floor on her bottom. The resident stated she was trying to close the blinds when she fell . Resident #45 had no injuries. The new intervention to prevent further falls was a sign placed in her room to remind her to call for help. LPN #3 stated Resident #45 had dementia and would forget to call for help so he thought the reminder signs would be a good intervention to remind Resident #45 to call for help. LPN #3 was also responsible for the resident when she fell on [DATE]. The LPN and a CNA heard a loud noise from the resident's room and went to check on her. Resident #45 was in the floor and stated she was trying to get into the big chair from her bed. Resident #45's nose was bleeding, and she had a skin tear on the bridge of her nose. Resident #45 stated she hit her head and complained of a headache. LPN #3 notified the physician and received an order to send the resident to the emergency room for evaluation. The LPN had another staff member stay in the room with the resident while he notified the physician. Resident #45 returned to the facility about 6 hours later. The LPN stated he provided reminders for the resident to call for help and to use her walker every time he saw her, and the nurse on the floor comes up with the new intervention after the fall to prevent future falls. The DON then reviews the intervention to determine if it was appropriate. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/14/2024 at 11:27 AM, Registered Nurse (RN) #1 stated Resident #45 was alert to self and situation at times, mostly just alert to self. The resident's memory .was not very good . and she would forget things after just a few minutes. RN #1 was responsible for the resident when she fell on [DATE]. The CNA notified RN #1 while she was getting shift report that the resident was in the floor in her room. RN #1 entered the room and found the resident on the floor. Resident #45 stated she was trying to go to the bathroom. No injury was noted immediately after the fall. The RN stated .I think my new intervention was to provide education . The RN stated providing education to the resident to call for help .probably . wasn't effective in preventing her from falling. The resident would verbalize understanding when you educated her, but she would forget shortly after. During an interview on 2/14/2024 at 3:37 PM, the DON stated nurses were responsible to come up with new interventions after a fall to prevent further falls. The Interdisciplinary Team (IDT) meets daily Monday through Friday to discuss falls and new interventions to ensure the new interventions are appropriate. The resident had dementia and a BIMS score of 3 indicating the resident had .severe dementia . The intervention to remind the resident to use the call light was not appropriate for the resident with a BIMS of 3, severe dementia, and multiple falls. The resident fell again on 2/6/2024 and was transferred to the ER and was diagnosed with an abrasion to the nose. The DON confirmed the resident was harmed as a result of the fall on 2/6/2024. During an interview on 2/14/2024 at 5:44 PM, the Administrator confirmed the resident had a diagnosis of Dementia and had a BIMS score of 3 which meant the resident had .severe memory problems . This surveyor reviewed the resident's falls and interventions with the Administrator. After the resident's first fall on 1/14/2024, the new interventions were to keep the call bell, fluids, and personal items within the resident's reach (already in place on the care plan dated 1/6/2024) and to put reminder signs in the room for the resident to call for assistance. The resident fell again on 1/22/2024, and the new intervention was to keep the bed in the lowest position at all times and to encourage the resident to use her walker. The resident fell for a 3rd time on 1/26/2024, and the new intervention to prevent further falls was to remind the resident to push the call light and to keep the room well lit and clutter free. The intervention for adequate lighting and keeping the room clutter free was already an intervention that was put into place on 1/6/2024. This surveyor asked the administrator if providing reminders to a resident with dementia and severe memory impairment with multiple falls was an appropriate fall prevention intervention and the Administrator stated .We probably should have come up with something else. It was not an appropriate intervention . The Administrator confirmed that reminding the resident to call for assistance via signage placed in her room was already an intervention put into place after the first fall and was not effective as the resident continued to get up without assistance. The resident fell for a 4th time on 2/6/2024 and obtained a nosebleed and skin tear to her nose and required transfer to the emergency room for evaluation. The Administrator confirmed the resident was harmed when she required evaluation in the emergency room and received an abrasion to her nose. During a telephone interview on 2/14/2024 at 5:59 PM, the Medical Director confirmed providing reminders to a resident with dementia .probably didn't help . and was not an appropriate intervention to prevent falls. The Medical Director stated, .Unfortunately yes. I think she was . when this surveyor asked if the resident was harmed from the fall on 2/6/2024 when the resident required transfer to the emergency department with an abrasion to the nose after the fall on 2/6/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing Home	878-880 West Main Street Pleasant Hill, TN 38578

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on 2/15/2024 at 6:33 PM, the Medical Director confirmed Resident #45's fall interventions were inappropriate for the resident's mental status. The Medical Director stated he did not believe the resident was harmed based on the definition of harm (resource unknown) from the fall on the 2/6/2024 but the resident was injured from the fall on 2/6/2024. The facility failed to implement appropriate interventions, modify fall interventions, and provide adequate supervision for a cognitively impaired resident, per the facility's policy, which resulted in actual harm to Resident #45.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on medical record review, observation and interview, the facility failed to complete side (bed) rail assessments for the risk of entrapment and failed to obtain consents for side rails for 6 residents (Residents #1, #34 #5, #23, #25 and #45) of 6 residents reviewed for side rails. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses including Cognitive Communication Deficit, Quadriplegia and Bed Confinement Status. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #1 had moderate cognitive impairment and required extensive assistance of 2 staff for bed mobility, hygiene and dressing and total dependence on staff for toileting. Review of Resident #1's medical record showed no entrapment risk safety assessments or consent for siderails. During an observation on 2/12/2024 at 12:40 PM, Resident #1 was listening to the radio while lying in bed and 1/4 bilateral upper side rails were in place on the bed. No visible gaps between the matress and siderails with concerns related to entrapment were observed. During an observation and interview with the Administrator on 2/13/2024 at 2:40 PM, in Resident #1's room, the Administrator confirmed 1/4 bilateral upper siderails were present on the resident's bed. The resident was lying in the bed and no visible gaps between the matress and siderails with concerns related to entrapment were observed. Resident #34 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Anemia, Depression, Primary Hypertension, Hyperlipidemia and Overactive Bladder. Review of the quarterly MDS assessment dated [DATE], showed Resident #34 had moderate cognitive impairment and had no negative moods or behaviors. The resident required supervision with toilet transfers and chair to chair/bed transfers, and sit to stand transfers required set up only. Review of Resident #34's medical record showed no entrapment risk safety assessments or consent for siderails. During an observation and interview with the Administrator on 2/13/2024 at 2:44 PM, in Resident #34's room, the Administrator confirmed 1/4 bilateral upper siderails were present on the resident's bed. No visible gaps between the matress and siderails with concerns related to entrapment were observed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 2/14/2024 at 9:59 AM, Resident #34 was sitting in a recliner next to her bed on which 1/4 bilateral upper siderails were in place. No visible gaps between the matress and siderails with concerns related to entrapment were observed. Resident #5 was admitted to the facility on [DATE] with diagnoses including Altered Mental Status, Vascular Dementia, Chronic Respiratory Failure, and Heart Failure. Review of the quarterly MDS assessment dated [DATE], showed Resident #5 was cognitively intact. The resident required supervison with sit to stand, roll left and right, chair to bed/bed to chair transfers, sit to lying, toilet transfers, and lying to sitting on the side of the bed. Review of Resident #5's medical record showed no entrapment risk safety assessments or consent for siderails. During an observation and interview with the Administrator on 2/13/2024 at 2:46 PM, in Resident #5's room, the Administrator confirmed 1/4 bilateral upper siderails were present on the resident's bed. The resident was lying in the bed and no visible gaps between the matress and siderails with concerns related to entrapment were observed. Resident #23 was admitted to the facility on [DATE] with diagnoses including Hemiplegia Following Cerebral Infarction, Vascular Dementia, and Hypertension. Review of the quarterly MDS assessment dated [DATE], showed Resident #23 was cognitively intact. The resident required substantial/ maximal assistance for walking, sit to stand, roll left and right, chair to bed/bed to chair transfers, sit to lying, toilet transfers, and lying to sitting on the side of the bed. Review of Resident #23's medical record showed no entrapment risk safety assessments or consent for siderails. During an observation and interview on 2/13/2024 at 2:45 PM, in Resident #23's room, the Administrator confirmed 1/4 bilateral upper siderails were present on the resident's bed. No visible gaps between the matress and siderails with concerns related to entrapment were observed. Resident #25 was admitted to the facility on [DATE] with diagnosis including Alzheimer's Disease, Chronic Kidney Disease, Type 2 Diabetes Mellitus and Hypertension. Review of the quarterly MDS assessment dated [DATE], showed Resident #25 sometimes made self-understood and sometimes understood others. Continued review revealed showed the interview to assess Resident #25's cognitive status was not perfomred due the resident rarely/never understood. The resident was totally dependent on staff for bed/bed to chair transfers, sit to lying, toilet transfers, and lying to sitting on the side of the bed. Review of Resident #25's medical record showed no entrapment risk safety assessments or consent for siderails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation and interview on 2/13/2024 at 2:46 PM, in Resident #25's room, the Administrator confirmed 1/4 bilateral siderails were present on the resident's bed. The resident was lying in the bed with no visible gaps between the matress and siderails with concerns related to entrapment were observed. Resident #45 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Encephalopathy (a brain disease that alters brain function), Subsequent Encounter for Fall, Dementia, Muscle Weakness, Abnormalities of Gait and Mobility, Difficulty in Walking, and Cognitive Communication Deficit. Review of the admission MDS assessment dated [DATE], showed Resident #45 had severe cognitive impairment. The resident required partial/moderate assistance for walking, sit to stand, roll left and right, chair to bed/bed to chair transfers, sit to lying, toilet transfers, and lying to sitting on the side of the bed. During an observation and interview on 2/12/2024 at 12:46 PM, Resident #45 was seated in the recliner in her room. There was a walker at the bedside and the resident's bed had 1/4 bilateral upper siderails. No visible gaps between the matress and siderails with concerns related to entrapment were observed. During an observation on 2/13/2024 at 5:55 AM, Resident #45 was lying in bed sleeping. Resident #45 had 1/4 bilateral upper siderails up on the bed. No visible gaps between the matress and siderails with concerns related to entrapment were observed. During an observation and interview with the Administrator on 2/13/2024 at 2:35 PM, in the Resident #45's room, the Administrator confirmed 1/4 bilateral upper siderails were present. No visible gaps between the matress and siderails with concerns related to entrapment were observed. During an interview on 2/13/2024 at 2:58 PM, the Administrator and Director of Nursing (DON) stated siderails came attached to the facility beds and had not been added by the facility. The DON and Administrator confirmed no alternatives had been attempted, no nursing assessments had been conducted for risks of entrapments, and no risks or benefits were discussed or consents obtained from the residents or their representatives. The DON confirmed there was no facility policy for siderails. 41782 45837

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405 Based on policy review, review of prior survey results, medical record review, facility documentation review, observation and interview, the facility's Quality Assurance Performance Improvement (QAPI) program failed to take effective actions plans to ensure appropriate interventions were put into place, and to monitor the effectiveness for falls for 1 resident (Resident #45) of 5 residents reviewed for falls. The findings include: Review of the facility's policy titled, Quality Assurance & Performance Improvement (QAPI) Plan, dated 9/21/2023, showed, .The QAPI plan .is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach .Objectives of the QAPI plan include .establish a facility-wide process to identify opportunities of improvement through continuous attention to quality of care, quality of life and resident safety . Review of prior survey findings, the facility was previously cited a deficiency of F689 on a complaint survey on 6/6/2023 at a Harm level. Review of the Plan of Correction (POC) for the 6/6/2023 complaint survey completed 7/30/2023 showed actions plans, and monitoring continued until 9/30/2023. The interventions included .The DON (Director of Nursing) will review the medical record of residents reported to have experienced a fall in the daily clinical meeting to ensure an appropriate intervention was implemented .The DON will also review the fall investigation with the clinical team to identify the root cause of the fall .The corrective actions will be monitored to ensure that an incident like this does not occur again or become a practice . Further review of the fall QAPI program showed there had been no concerns identified after the monitoring had been completed in 9/2023 (for the deficiency cited 6/2023). Continued review showed the QAPI program failed to identify the inappropriate fall interventions and/or lack of new interventions implemented after each of the falls for Resident #45. Resident #45 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Encephalopathy (a brain disease that alters brain function), Subsequent Encounter for Fall, Dementia, Muscle Weakness, Abnormalities of Gait and Mobility, Difficulty in Walking, and Cognitive Communication Deficit. Review of the Admission assessment dated [DATE], showed Resident #45 had short and long term memory problems. Resident #45 had 3 or more falls in the last 3 months, required assistance for ambulation, had unstable balance, intermittent confusion, and gait problems while standing and while walking. Review of the care plan dated 1/6/2024, showed Resident #45 .Has risk factors for falls . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility investigation documentation showed Resident #45 had an unwitnessed fall on 1/14/2024 at 6:15 PM in her room, .Resident stated that she was attempting to get out of her recliner, in order to close her blinds, scooted down the chair and slipped out of it, onto the floor .Nurse closed residents blinds and reeducated resident on call light use, following that, nurse assisted into a lying position .Reminder signs, and Stop signs put up in view of patient .No Apparent Injury . Review of the care plan updated on 1/14/2024, showed .At risk for injurious falls related to weakness, unsteadiness, impaired balance .1/14/24 Keep call bell, fluids, and personal items within [Resident #45's] reach [call bell and items in reach was an intervention in place on 1/6/2024 and not new interventions] .Put reminder signs in room .Reminder & [and] Stop signs placed withing [within] Elder's view to remind Elder to call for assistance when she needs help [Resident #45 had poor short term and long term memory loss and had cognitive impairment] . Review of the facility's investigation documentation showed the resident had a 2nd unwitnessed fall on 1/22/2024 at 6:40 AM, in the hallway. It was noted .I [Resident #45] don't know why I fell or why I'm here . elder assessed for injury .Environmental Factors: Ambulation WITHOUT Gait Device . Review of the care plan updated on 1/22/2024, showed .1/22/24 Keep bed in lowest position at all times when not working at the bedside [the resident fell in the hallway and not from the bed]. Encourage resident to use her walker . Review of the Nursing Interdisciplinary Notes dated 1/26/2024, showed a 3rd fall.Elder found in floor at 0545 [5:45 AM] .elder was .'trying to go to bathroom' .Education provided to call for assistance for ambulation/transfers/toileting .[reminder signs to call for assistance were placed in the resident's sight on 1/14/2024 and resident was encouraged to use walker after 1/22/2024 fall . The interventions put into place were not new interventions. Review of the care plan updated on 1/26/2024, showed .1/26/24 Reminder to push call light [reminder signs placed within resident's sight on 1/14/2024] and Keep room well lit and clutter free [previous intervention dated 1/6/2024, no new intervention put into place]. Resident often prefers lights out . Review of the facility's fall investigation documentation showed the resident had a 4th fall, the unwitnessed fall was in the resident's room on 2/6/2024 at 12:30 AM, .Location Specifics: In front of the window .This nurse and CNA [Certified Nursing Assistant] .entered residents room to find her on the floor sitting with her left arm supporting her and her right hand up to her nose. Nurse assessed resident and found superficial skin tear to midline nasal dorsum, as well as mild epistaxis [nosebleed] from left nostril .Resident voiced c/o [complaints of] headache .No other injuries were noted .@ [at] 0035 [12:35 AM] M.D. [Medical Doctor] ordered this resident to be sent to ER [emergency room] for further evaluation .Resident's Description: Resident stated that she was attempting to ambulate to the large chair next to the window, but lost her balance. She stated that she hit her head during the incident, and complained of headache like pain . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the hospital Emergency Documentation dated 2/6/2024, showed XXX[AGE] year-old FEMALE TO THE EMERGNECY DEPARTMENT BY AMBULANCE FROM NURSING HOME WITH REPORT OF FALL WITNESSED TONIGHT. fell FACE FORWARD .ABRASION ON BRIDGE OF NOSE. HISTORY OF GAIT INSTABILITY AND FREQUENT FALLS .NO ACTIVE BLEEDING. NO OTHER ACUTE COMPLAINTS . PATIENT WITH HISTORY OF ADVANCED DEMENTIA .Physical Exam .Head .ABRASION TO NOSE .CT [Computed Tomography] Brain/Head .FINDINGS .IMPRESSION .No definite acute intracranial abnormality . No hemorrhage .Diagnosis: Abrasion of nose; Ground-level fall; Unsteady gait .CONTINUE ALL CURRENT MEDICATION. CONTINUE MEASURES TO PREVENT FUTURE FALLS . The resident was discharged back to the facility on [DATE] at 4:05 AM. During an observation on 2/13/2024 at 5:55 AM, Resident #45 was lying in bed sleeping. Resident #45 had 1/4 bilateral upper side rails up on bed, a walker at the bedside, and an alarm was attached to the resident's clothing. The bed was low and locked, call light was in reach, and reminder signs to call for help were posted on the resident's closet door. During an interview and review of facility documentation and Resident #45's medical record on 2/13/2024 at 10:33 AM, with the Director of Nursing (DON) revealed the resident had 4 falls while at the facility. The resident was at high risk for falls. Resident #45 had an unwitnessed fall in her room on 1/14/2024 at 6:15 PM. The resident was found in the floor in front of her recliner and said she was trying to close her blinds. The new intervention to prevent further falls was to put reminder signs up in her room. Resident #45 had an unwitnessed fall on 1/22/2024 and was found in the hallway on the floor by housekeeping. Resident #45 obtained a skin tear on her right elbow. The new intervention to prevent further falls was to encourage the resident to use her walker and bed in the lowest position. Resident #45 had an unwitnessed fall on 1/26/2024 and was found in her room on the floor next to her heater. The resident said she was trying to go to the bathroom when she fell , and she hit her head. The new intervention to prevent further falls was to remind her to use the call light and keep her room well-lit and clutter free, the DON confirmed the intervention to provide adequate lighting was already in place and not a new intervention. The DON confirmed Resident #45 had dementia, poor cognition, and multiple falls so reminding the resident to use the call light was not an appropriate intervention to prevent further falls. The DON confirmed no new appropriate interventions were implemented after the resident's 3rd fall on 1/26/2024. Resident #45 had another unwitnessed fall on 2/6/2024 in her room and was sent to the ER for further evaluation. The DON stated .we were kind of at a loss for new interventions .we had exhausted everything we knew to do . (continued on next page)

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and review of the fall documentation with the Administrator on 2/14/2024 at 5:44 PM, the Administrator confirmed the resident had a diagnosis of Dementia and had a Brief Interview for Mental Status (BIMS) score of 3 which meant the resident had .severe memory problems . After the resident's first fall on 1/14/2024, the new interventions were to keep the call bell, fluids, and personal items within the resident's reach (already in place on the care plan dated 1/6/2024) and to put reminder signs in the room for the resident to call for assistance. The resident fell again on 1/22/2024, and the new intervention was to keep the bed in the lowest position at all times and to encourage the resident to use her walker (the resident did not fall from the bed). The resident fell for a 3rd time on 1/26/2024, and the new intervention to prevent further falls was to remind the resident to push the call light and to keep the room well lit and clutter free which were interventions put into place on 1/6/2024. This surveyor asked the administrator if providing reminders to a resident with dementia and severe memory impairment with multiple falls was an appropriate fall prevention intervention and the Administrator stated .We probably should have come up with something else. It was not an appropriate intervention . The Administrator confirmed that reminding the resident to call for assistance via signage placed in her room was already an intervention put into place after the first fall and was not effective as the resident continued to get up without assistance. The resident fell for a 4th time on 2/6/2024 and obtained a nosebleed and skin tear to her nose and required transfer to the emergency room for evaluation. The Administrator confirmed the resident was harmed when she required evaluation in the emergency room and received an abrasion to her nose. During a telephone interview on 2/14/2024 at 5:59 PM, the Medical Director confirmed providing reminders to a resident with dementia .probably didn't help . and was not an appropriate intervention to prevent falls. During an interview with the Administrator and the DON on 2/22/2024 at 8:02 AM, showed the fall QAPI program was discussed as follows: 1. The DON stated, if a fall or an issue with a fall was identified, the fall was discussed during the QAPI meetings and IDT meetings along with any problem areas identified. The DON stated, No problem areas were identified in QAPI regarding falls. 2. The DON stated she believed the facility had an effective fall QAPI program. When the DON was questioned further regarding the 4 falls of Resident #45 and if the resident had appropriate and new interventions after each fall, the DON stated, .I can't answer your question . The DON stated on-going monitoring by way of audits had been conducted from 6/2023 to 9/2023 and included monthly fall and pain assessments for all residents, If they [residents] have a fall [the facility] redo a new fall and pain assessment. 3. The DON stated she felt there had been continued monitoring related to falls and we talk about falls every single day with oversight provided by the whole team (Therapy Department, Social Services, Activities Department, Assistant Director of Nursing, the Director of Nursing, and the Administrator). When the DON was asked, how did she feel the fall QAPI program was effective related to Resident #45's falls, the DON stated .at the time I did [think it was effective] after talking with you I don't know . (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. The Administrator stated the Interdisciplinary Team (IDT) members included Physical Therapy representative, the Administrator, the Social Services Director, the Activities Coordinator, the Minimum Data Set Coordinator, the Director of Nursing, and the Assistant Director of Nursing met to discuss resident falls and make the determination if the fall interventions which had been put into place were appropriate and the interventions were revisited if a resident continued to fall. Continued interview showed there had been no issues related to the fall interventions for Resident #45. 5. The DON stated when asked if there had been any adjustments in the fall QAPI program after Resident #45 or other residents continued to have falls prior to this survey the DON stated NO. During the interview on 2/22/2024 at 8:17 AM, with the DON and Administrator when questioned if they felt the action plans which had been initiated were not sustained and the facility failed to ensure an effective QAPI to prevent further falls. The DON stated I can't answer that question .to be honest I don't know .did QAPI implement anything to prevent .Prior to this survey I thought we were doing well . The Administrator stated .I feel like we do everything we can to keep them (residents) from falling not sure what you guys [State Survey Agency] want us to do . Refer to F689.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, observation, and interview, the facility failed to offer hand hygiene assistance to residents prior to meals for 3 residents (Resident #44, #156, and #157) of 3 residents observed on 1 of 3 hallways observed for meal tray distribution. The findings include: Review of the facility's policy titled, Hand Hygiene, updated on 8/21/2023, showed .POLICY .will perform proper hand hygiene procedures to prevent the spread of infection .Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table .Hand Hygiene Table .Residents are offered hand hygiene prior to meals .Either Soap and Water or Alcohol Based Hand Rub . Resident #44 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Alzheimer's Disease, and Cognitive Communication Deficit. Review of Resident #44's admission Minimum Data Set (MDS) assessment dated [DATE], showed the resident had a Brief Interview for Mental Status (BIMS) score of 4, indicating the resident had severe cognitive impairment. Resident #44 was independent for eating and personal hygiene. Resident #156 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Encephalopathy, Muscle Weakness, and Cognitive Communication Deficit. Review of Resident #156's admission MDS assessment dated [DATE], showed the resident had a BIMS score of 6, indicating the resident was severely cognitively impaired. Resident #156 was independent for eating and required setup or clean up assistance with personal hygiene. Resident #157 was admitted to the facility on [DATE] with diagnoses including Encounter for Surgical Aftercare Following Surgery of the Digestive System, Ulcerative Colitis, Colostomy, Parkinson's Disease, and Osteoarthritis. During an observation on 2/12/2024 at 12:35 PM, Certified Nursing Assistant (CNA) #1 delivered the lunch tray to Resident #157. CNA #1 assisted the resident to set up the lunch tray and exited the room without offering hand hygiene assistance to the resident. During an observation on 2/12/2024 at 12:37 PM, CNA #1 delivered the lunch tray to Resident #156. CNA #1 assisted the resident to set up the lunch tray and exited the room without offering hand hygiene assistance to the resident. During an observation on 2/12/2024 at 12:39 PM, Licensed Practical Nurse (LPN) #1 delivered the lunch tray to Resident #44. LPN #1 assisted the resident to reposition in bed and set up the lunch tray. LPN #1 exited the room without offering hand hygiene assistance to the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445510	A. Building B. Wing	02/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wharton Nursing Home	878-880 West Main Street Pleasant Hill, TN 38578

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/12/2024 at 12:40 PM, LPN #1 stated residents were to be offered hand sanitizer or sanitizer wipes prior to meals. LPN #1 confirmed she had not offered hand hygiene assistance to Resident #44 prior to the meal and stated .I forgot to do that .that's on me . During an interview on 2/12/2024 at 12:41 PM, CNA #1 stated residents were to be offered hand sanitizing wipes or a washcloth prior to meals. CNA #1 confirmed she had not offered hand hygiene assistance to Residents #156 and #157 prior to their lunch meal. During an interview on 2/12/2024 at 4:04 PM, the Director of Nursing (DON) stated it was her expectation that staff offered or provided hand hygiene assistance to residents prior to meals using hand sanitizing wipes, sanitizing gel, or wet washcloth. During an interview on 2/14/2024 at 8:07 AM, the Infection Preventionist (IP) confirmed residents were to be offered hand hygiene assistance with hand sanitizing wipes or hand sanitizer prior to meals. The IP stated all staff have been educated on that process.