STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445523	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellpark at Shannondale	7512 Middlebrook Pike Knoxville, TN 37909

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** 41782 Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure the resident's right to dignity was protected for 1 resident (Resident #11) of 30 residents reviewed for dignity. The findings include: Review of the facility's policy titled, Dignity, revised 2/2021, revealed .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem .Residents are treated with dignity and respect at all times .Staff protect confidential information. Examples include the following .Signs indicating the resident's clinical status or care needs are not openly posted in the resident's room unless specifically requested by the resident or family member. Discreet posting of important clinical information for safety reasons is permissible (e.g., taped to the inside of the door) . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Diabetes, and Hypertension. Review of the comprehensive care plan for Resident #11 dated 12/16/2024, revealed no evidence of the sign being requested by the resident or family. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. During an observation and interview, in Resident #11's room, on 1/21/2025 at 11:50 AM, revealed there was a sign posted above the resident's bed that read, .No B/P [blood pressure] [to] R [right] Arm . The sign was visible to anyone that entered Resident #11's room. Resident #11 stated he was unaware who had posted the sign and stated he had not requested the sign be posted. The resident stated the signage posted did not bother him. During an observation on 1/22/2025 at 9:21 AM, there was a sign posted above the resident's bed that read, . No B/P [to] R Arm . (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	During an interview on 1/22/2025 at 2:14 PM, the Director of Nursing (DON) stated resident care information was to be communicated to the staff either in a verbal report or the kardex or care plan. The DON stated signs were not to be posted in resident rooms unless requested by the resident or family. The DON further stated if signs were requested, there should be an entry in the medical record regarding the request. During an observation and interview on 1/22/2025 at 2:23 PM, with the DON, in Resident #11's room, Resident #11 was lying in bed with a sign posted above the bed that read, .No B/P [to] R Arm . The DON confirmed the sign was visible to anyone that entered Resident #11's room. The DON was unaware who had requested the sign to be posted and why it had been posted. During an interview on 1/22/2025 at 3:09 PM, the DON confirmed there was no information in Resident #11's medical record to indicate the resident had requested the sign to be posted.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy reivew, the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual review, medical record review and interview, the facility failed to accurately complete Minimum Data Set (MDS) assessments for 1 residents (Resident #22) for falls and for 1 resident (Resident #31) for discharge location of 11 residents reviewed for MDS assessments. The findings include: Review of the faiclity's policy titled, Certifying Accuracy of the Resident Assessment, dated 11/2019, revealed .Any person completeing a portion of the .MDS .must sign and certify the accuracy of that portion of the assessment .The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment . Review of the RAI Version 3.0 Manual dated 10/2024, revealed .documents the location to which the resident is being discharged at the time of discharge .Review the medical record including the discharge plan .discharge orders for documentation of discharge location .Review all available sources for any fall since the last assessment . Medical record review revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Age-Related Osteoporosis with Pathological Fracture, Left Femur Fracture, Adjustment Disorder with Depressed Mood, and Unsteadiness on Feet. Review of the facility fall documentation dated 10/5/2024, revealed Resident #22 had a witnessed fall on 10/5/2024 at 4:30 PM, in the resident's room with no injuries. Review of the admission MDS assessment dated [DATE], revealed Resident #22 had a fall with fracture prior to admission/re-entry. The resident had no falls since admission re-entry. During an interview on 1/23/2025 at 9:01 AM, MDS Coordinator stated Resident #22's 10/7/2025 admission MDS assessment revealed the resident had no falls since admission. The MDS Coordinator confirmed the admission MDS assessment was inaccurate and did not reflect the resident's fall on 10/5/2024. 41291 Medical record review revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including COVID-19, Pneumonia, Urinary Tract Infection, and Severe Sepsis. Review of the discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #31 had a planned discharge to the hospital with return not anticipated. Review of the Discharge Summary for Resident #31 dated 11/27/2024, revealed the resident discharged home with spouse. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 12:05 PM, the MDS Coordinator confirmed the discharge MDS assessment for Resident #31 dated 11/27/2024 was not accurate assessment. Based on the medical record Resident #31 was discharged home and not to the hospital. The MDS Coordinator stated her expectation was for MDS assessments to be completed and accurate based on medical record review.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, and interview, the facility failed to develop a comprehensive care plan timely for pressure ulcers for 1 resident (Resident #11) of 2 residents reviewed for wounds of 4 residents sampled. The findings include: Review of the facility's policy titled, Skin and Wound Monitoring and Management, revised on 12/2023, revealed .Facility nursing staff will identify and document in the resident's clinical records, the condition and pressure injury risk factors .implementation of a plan of care will begin at admission with the initial care plan and be completed throughout assessment process for developing a comprehensive plan of care . Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised on 12/2023, revealed .The facility IDT [interdisciplinary team] will develop and implement a comprehensive-person centered .care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Fracture of the Right Femur, Encounter for Orthopedic Aftercare, Type 2 Diabetes Mellitus, and End Stage Renal Disease. Review of a Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE], revealed Resident #11 was at high risk for pressure ulcers. Review of a Wound assessment dated [DATE], revealed Resident #11 had a right heel Deep Tissue Injury (DTI) wound that was present on admission. Interventions included .Seating Redistributing Cushion .Pillows . Turn & Repositioning . Review of a Wound assessment dated [DATE], revealed Resident #11 developed a new Stage 2 pressure wound to the sacrum. Interventions included .Seating Redistribution Cushion .Pillows .Turn & Repositioning . Review of an admission MDS assessment dated [DATE], revealed Resident #11 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #11 was at risk for pressure ulcer/pressure injuries and had a stage 2 pressure ulcer that was not present on admission and 2 unstageable deep tissue injuries that were present on admission. Skin and ulcer treatments included pressure reducing device for bed, nutrition or hydration interventions to manage skin problems, pressure ulcer/pressure injury care, application of nonsurgical dressings other than to feet, and application of ointments/medications other than to feet. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Recap Report for Resident #11 revealed a physician's order dated 12/29/2024, for . ENCOURAGE NO SHOE TO RIGHT FOOT TO REDUCE PRESSURE TO HEEL AS RESIDENT ALLOWS. ELEVATE AS RESIDENT ALLOWS TO REDUCE .PRESSURE . Continued review revealed .WOUND CARE RIGHT HEEL PRESSURE ULCER, OFFLOAD AT ALL TIMES . Review of the facility's undated timeline for Resident #11's right heel wound revealed .R [right] heel wound identified on 12/12/2024 upon initial skin admission .Interventions for seating redistribution cushion, pillows . turning and repositioning . Continued review revealed .Wound assessment completed on 1/3/2025 .New intervention for Heel manager put into place . Continued review revealed .Wound assessed 1/15/2025 . Interventions for seating redistribution cushion, pillows .turning and repositioning, air mattress applied to bed . Review of the facility's undated timeline for Resident #11's sacral wound, revealed .Sacral Wound identified on 12/15/2024 .Interventions for seating redistribution cushion, pillows . turning and repositioning . Continued review revealed .Wound assessed on 1/15/2025 .Interventions for seating redistribution cushion, pillows . turning and repositioning, air mattress applied to bed . Review of the comprehensive care plan for Resident #11 initiated on 1/21/2025 (35 days past the completion of the MDS assessment), revealed .pressure ulcer to sacrum, Stage 3 facility acquired 12/17/24 .Suspected Deep tissue injury to right heel, admit with 12/11/24 .Administer medications as ordered .Administer treatments as ordered and monitor for effectiveness .Assess/record/monitor wound healing. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [medical doctor] .Call light within reach .Encourage fluid intake and assist to keep skin hydrated .Encourage to turn and reposition, provide assistance as necessary .If refuses treatment, meet with resident, IDT and family to determine why and try alternative methods to gain compliance. Document alternative methods .Inform resident, family/caregivers of any new area of skin breakdown .Monitor nutritional status. Serve diet as ordered, monitor intake and record . Monitor/document/report to MD PRN [as needed] changes in skin status: appearance, color, wound healing, s/sx [signs and symptoms] of infection, wound size and stage .Treat pain as per orders prior to treatment/turning . During an interview on 1/23/2025 at 10:27 AM, the MDS Coordinator stated the MDS department was responsible for developing and updating care plans. The MDS Coordinator stated staff knew what interventions were in place to prevent and address pressure ulcers from word of mouth and from the care plan. The MDS Coordinator confirmed the admission MDS assessment dated [DATE] captured Resident #11's risk for pressure ulcers and actual pressure ulcers and a care plan should have been developed to address them within 7 days of completion. The MDS Coordinator stated Resident #11's care plan did not include a care plan to address pressure ulcers until 1/21/2025. During observations of Resident #11 on 1/21/2025 at 11:50 AM, 1/21/2025 at 2:34 PM, 1/22/2025 at 2:23 PM, 1/23/2025 at 9:45 AM, 1/23/2025 at 7:20 PM, and 1/23/2025 at 9:19 PM, revealed no concerns related to pressure ulcer interventions being in place. During interviews with staff responsible for Resident #11 throughout the survey period of 1/21/2025 - 1/24/2025, revealed the staff were aware of interventions for pressure ulcers including turning/repositioning, air mattress, offloading of heels, encouraging no shoe to the right foot, and heel manager. Staff reported interventions were discussed in report and available to view on the care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, and interview, the facility failed to ensure a care plan was revised to include new interventions after a fall for 1 resident (Resident #22) of 3 residents reviewed for falls. The findings include: Review of the facility's policy titled, Falls and Fall Risk, Managing, revised 3/2018, revealed .staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling . Resident-Centered Approaches to Managing Falls and Fall Risk .staff .will implement a resident-centered fall prevention plan to reduce the specific risk factors of falls for each resident at risk or with a history of falls .If falling recurs despite initial interventions, staff will implement additional or different interventions . Review of the facility's policy titled, Comprehensive Person-Centered Care Planning, revised on 12/2023, revealed .It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives .to meet a resident's .needs .Interventions .are actions, treatments, procedures, or activities designed to meet an objective . Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Age-Related Osteoporosis with Pathological Fracture, Left Femur Fracture, Fracture of the Lower End of Left Radius and Ulna, and Unsteadiness on Feet. Review of an Admission Fall Risk Evaluation dated 10/1/2024, revealed Resident #22 scored a 7 which indicated the resident was at medium risk for falls. Review of the Baseline Care Plan dated 10/2/2024, revealed Resident #22 was alert and always continent of urine and bowel. Resident #22 had a history of falls and used a walker and wheelchair for mobility. Review of the facility's fall investigation documentation revealed Resident #22 had a witnessed fall in the resident's room on 10/5/2024 at 4:30 PM. It was noted .CNA [Certified Nursing Assistant] report while transferring patient from recliner to wheelchair patient slide to floor and landed on bottom .Patient report not hitting head .no present pain .VSS [vital signs stable] .declined ER [emergency room] visit .No injuries . The new intervention was .Use gait belt with all transfers . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #22 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Resident #22 had limited range of motion of one side of the upper and lower extremities and required a wheelchair for mobility. Resident #22 required substantial/maximal assistance for sit to stand, chair/bed-to-chair transfer, and toilet transfers. Resident #22 had a a fall with fracture prior to admission and no falls since admission. The resident was frequently incontinent of urine and occasionally incontinent of bowel. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's fall investigation documentation revealed Resident #22 had an un-witnessed fall in the resident's room on 10/16/2024 at 11:00 AM. It was noted .Observed resident sitting on floor in front of recliner chair in resident room .Resident Description: Slipped off chair .Immediate Action Taken . [Dycem-anti-slip material] to recliner chair .No Injuries observed at time of incident . Resident #22 was wearing appropriate footwear at the time of the fall. Review of the comprehensive care plan for Resident #22 dated 10/18/2024, revealed .at risk for falls related to weakness, debility, history of falls . Interventions included .Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance .Educate the resident/family/caregivers about safety reminders .Encourage the resident to participate in activities and promote exercise, physical activity for strengthening and improved mobility .Ensure that The resident is wearing appropriate footwear when ambulating or mobilizing in w/c [wheelchair] .Review information on past falls and attempt to determine cause of falls .remove any potential causes if possible. Educate resident/family/caregivers/IDT [interdisciplinary team] as to causes . Review of the facility's fall investigation documentation dated revealed Resident #22 had an unwitnessed fall on 11/1/2024 at 12:20 AM, in the resident's room. It was noted .patients pull the bathroom call light, RN [Registered Nurse] went into the room, found patient sitting on the floor, asks patient are you okay, and did you hit your head, or have pain anywhere, patient replied no. RN then assess patient, no bruising or pain noted. Vital signs taken .Patient teaching regarding safety and fall prevention .bed and chair alarms activated .encouraged to call for help at all times .patient said she thinks she can go to the bathroom without help and went there without calling and put herself on the toilet but when she was done and clean herself up, got up to sat in the wheelchair .when she lost balance and sat herself down and pull the bathroom light .Fall prevention teaching done .neuro checks .patient encouraged to call for help at all times .Low Bed . No injuries observed at time of incident . Review of an Order Summary Report for Resident #22 revealed an order dated 11/1/2024 for .Low Bed PSA [personal safety alarm] to bed and chair . Review of the comprehensive care plan for Resident #22 initiated on 1/20/2025, revealed .At risk for falls r/t [related to] weakness, debility, pain . Continued review revealed the care plan was revised on 1/21/2025 and included interventions of .Dycem to wheelchair .Low bed .Personal safety alarm to bed and chair . During an observation and interview in Resident #22's room, on 1/21/2025 at 2:34 PM, revealed the resident was seated in the recliner beside the bed visiting with her husband. Resident #22 reported she had fallen a few times while at the facility. Resident #22 and her husband reported the resident does not call for help before getting up. Resident #22 had chair and bed alarm in place, Dycem in wheelchair, bed in low position, call light in reach, non-skid socks on, and gait belt present in the resident's room. During observations of Resident #22 on 1/22/2025 at 9:23 AM and 1/23/2025 at 10:09 AM, revealed fall interventions were in place. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews throughout the survey period of 1/21/2025 - 1/23/2025, the staff responsible for Resident #22 stated they were aware of fall interventions in place. The staff knew fall interventions in place from verbal report and the care plan. During an interview on 1/23/2025 at 9:01 AM, the MDS Coordinator stated the MDS department were responsible to update the care plans. The MDS Coordinator stated falls were discussed daily in the morning IDT meeting to determine root cause and appropriate interventions and the care plan was to be updated with new interventions. During an interview on 1/23/2025 at 3:15 PM, the Director of Nursing (DON) stated the care plan was to be updated with the new interventions .as soon as possible . by the MDS Coordinator. The DON confirmed the new intervention for the gait belt with all transfers had not been added to the care plan. The DON confirmed the care plan had not been updated timely with the new intervention until 1/21/2025, and had not been added timely.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review and interview, the facility failed to ensure physician's orders for wound care were followed for 1 resident (Resident #11) of 2 residents reviewed for wounds of 4 residents sampled. The findings include: Review of the facility's policy titled, Skin and Wound Monitoring and Management, revised on 12/2023, revealed .It is the policy of this facility that .A resident having pressure injury(s) receives necessary treatment and services to promote healing, prevent infection . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Fracture of the Right Femur, Encounter for Orthopedic Aftercare, Type 2 Diabetes Mellitus, and End Stage Renal Disease. Review of a Wound assessment dated [DATE], revealed Resident #11 had a Deep Tissue Injury (DTI) to the right heel that was present on admission to the facility. The wound measured 6 centimeters (cm) x (by) 5.5 cm. Review of an Order Summary Report for Resident #11 revealed an order with a start date of 12/13/2024 for . R [right] heel: paint with betadine [antimicrobial solution] daily . Review of an admission Minimum Data Set (MDS) dated [DATE], revealed Resident #11 was at risk for pressure ulcer/pressure injuries and had a stage 2 pressure ulcer that was not present on admission and 2 unstageable deep tissue injuries that were present on admission. Further review revealed Resident #11 received dialysis while at the facility. Review of the Skin Pressure Ulcer Weekly document for Resident #11 dated 1/3/2025, revealed the DTI to the right heel measured 8.5 cm x 8.5 cm. It was noted .MD [medical doctor] aware of wound .Continue POC [plan of care] . Review of the Discontinue Order for Resident #11 dated 1/3/2025, revealed the order to paint the right heel with betadine daily was discontinued by the Wound Care Nurse .Reason for Discontinue .resolved . Review of the Treatment Administration Record (TAR) dated 1/4/2025 - 1/22/2025, revealed Resident #11 received no treatment to the right heel DTI from 1/4/2025 - 1/22/2025 (19 days). Review of the Skin Pressure Ulcer Weekly document for Resident #11 dated 1/8/2025, revealed the DTI to the right heel measured 7 cm x 8 cm. It was noted MD .aware of wounds .Wound to R heel remains intact and stable at this time . Review of the Skin Pressure Ulcer Weekly document for Resident #11 dated 1/15/2025, revealed the DTI to the right heel measured 7 cm x 4 cm. It was noted .Improved .MD .aware of wounds .Wound to R heel remains intact and stable at this time . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Order Summary Report for Resident #11 revealed an order with a start date of 1/23/2025 for . Apply betadine to right heel daily and cover with border gauze . Review of the TAR dated 1/23/2025, revealed Resident #11 received the betadine with border gauze treatment to the right heel according to the physician's order. Review of the nurse practitioner PROGRESS NOTE for Resident #11 dated 1/23/2025, revealed .Chief Complaint/Nature of Presenting Problem .Evaluation of breakdown to .right heel .past medical history . end-stage renal disease on hemodialysis admitted with SDTI [Suspected Deep Tissue Injury] to his right heel .Right heel is with intact eschar approximately 5.3 x 3.1 .no periwound erythema .no drainage .healing nicely . Right heel eschar continues to decrease in size .Wound care to continue to follow . During an interview on 1/23/2025 at 5:41 PM, the Wound Care Nurse stated Resident #11 had a right heel DTI present on admission. Treatment to the right heel included turning/repositioning at least every 2 hours, offloading of the heel, and an order to paint with betadine daily. The Wound Care Nurse stated the order for the daily betadine to the right heel was never discontinued. The Wound Care Nurse was notified .yesterday . (1/22/2025) by a nurse that there was no longer an order for betadine for the right heel and a new order was obtained to resume daily betadine with border gauze dressing to the right heel to treat the DTI. The Wound Care Nurse stated she evaluated wounds weekly and provided wound treatments on the date she evaluated the wound and nursing provided daily treatments on the other days. The Wound Care Nurse stated she was unaware the daily betadine treatment to the right heel DTI had not been administered from 1/4/2025 - 1/22/2025. The Wound Care Nurse stated the facility had changed ownership on 1/1/2025 and all orders had to be manually entered into the new computer system. The Wound Care Nurse evaluated Resident #11's right heel wound on 1/8/2025, 1/15/2025, and 1/23/2025 with no decline in the wound. During an interview on 1/23/2025 at 6:40 PM, the Director of Nursing confirmed the order for daily betadine to Resident #11's right heel wound was discontinued in error and had not been administered after 1/3/2025. The DON stated the wound had improved and no decline was noted. The DON confirmed it was her expectation that physician's orders were followed. During an observation with the Wound Care Nurse, in Resident #11's room, on 1/23/2025 at 9:31 PM, revealed Resident #11's wound to the right heel was consistent with the wound evaluation performed by the Nurse Practitioner and the Wound Care Nurse on 1/23/2025 with no concerns noted. During an interview on 1/24/2025 at 9:40 AM, the Nurse Practitioner (NP) stated Resident #11 not receiving the betadine treatment to the right heel daily from 1/4/2025 until it was resumed on 1/22/2025 did not cause harm to the resident. The NP stated the right heel wound had decreased in size and had not declined. The NP confirmed it was his expectation that wound care orders were followed. During an interview on 1/24/2025 at 11:25 AM, Licensed Practical Nurse (LPN) D stated she had been responsible for Resident #11's wound care on 1/10/2025. LPN D was unable to recall if she had provided the betadine treatment to Resident #11's right heel and stated if the order had been discontinued and there was no active order, she would not have administered it. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/24/2025 at 11:58 AM, Registered Nurse (RN) I stated she had been responsible for Resident #11's wound care on 1/11/2025 and 1/12/2025. RN I was unable to recall if she had provided the the betadine treatment to Resident #11's right heel and stated she would have only provided it if there was an active treatment on TAR. If the order had been discontinued it wouldn't have shown up to be given on the TAR and she would not have administered it if there was no active order. During an interview on 1/24/2025 at 12:31 PM, the Wound Care Nurse stated upon further investigation, she had discontinued the order for daily right heel DTI betadine on accident. The Wound Care Nurse stated she was reconciling the orders after the facility changed ownership and thought she had discontinued the order for the daily betadine treatment to the right ankle wound that already resolved. The Wound Care Nurse stated there had been no decline in Resident #11's right heel DTI wound. During an interview 1/24/2025 at 1:01 PM, the DON confirmed it was her expectation that treatments were administered according to physician's orders. The Wound Care Nurse had discontinued the order for Resident #11's right heel wound treatment in error and should not have been discontinued.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on facility policy review, medical record review and interview the facility failed to ensure a resident's weights were accurately recorded and monitored for 1 resident (Resident #28) of 4 residents reviewed for weight loss. The findings include: Review of the facility's policy titled, Weighing and Measuring the Resident, dated 3/2011, revealed .When weighing the resident the following guidelines will promote accurate weight assessment .weigh at the same time of day each time .use the same scale for weighing .weigh .with approximately the same amount of clothing .Be sure the weight scale is calibrated .Zero the scale .Weigh the wheelchair .record the resident's weight .Subtract the weight of the wheelchair .Report significant weight loss .to the nurse supervisor . Review of the medical record revealed Resident #28 was admitted to the facility 12/4/2024 with diagnoses including Sepsis, Severe Protein-Calorie Malnutrition, Dehydration, Anxiety, and Major Depressive Disorder. Review of the Physician's Orders for Resident #28 dated 12/4/2024, the resident was ordered a regular diet. Review of the Physician's Orders for Resident #28 dated 12/6/2024, revealed the resident was to be weighed weekly every Wednesday. Review of a Psychiatric Evaluation for Resident #28 date 12/10/2024, revealed an initial evaluation for depression.Patient recently admitted to facility following hospitalization for nausea and vomiting for several days. [Patient] has hx [history] of acute intermittent porphyria [a rare blood disease that affects the nervous system, which causes digestive symptoms such as severe belly pain, nausea, and vomiting] .Eats very little. He has been drinking [nutritional supplement] and [soda] almost exclusively . Review of Resident #28's recorded weights revealed: -12/4/2024- 231.0 sitting -12/5/2024- 224.8 wheelchair -12/11/2024- 221 wheelchair -12/18/2024- 226.4 standing -12/25/2024- 217.4 wheelchair -1/8/2025- 177.4 wheelchair (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-1/16/2025- 208.8 wheelchair -1/22/2025- 207.0 standing -1/23/2025- 208.8 (method unknown) Review of the percentage of meals eaten date ranged 1/5/2025-1/22/2025, revealed Resident #28 consumed an average of 75-100% (percent) of meals. Review of the Physician's Orders for Resident #28 dated 1/23/2025, revealed the resident was ordered a nutritional supplement 3 times a day with meals, an appetite stimulant, and to have laboratory values obtained for weight loss. During an interview on 1/23/2025 at 7:11 PM, the Director of Nursing (DON) stated the Certified Nursing Assistants (CNAs) are typically responsible for obtaining the residents' weights. There is a calendar located at the nursing desk which shows which residents needed to be weighed with the last recorded weight. The facility has different scales-a standing scale, scale for wheelchairs, and a mechanical lift scale. The DON stated it was her expectation for weight discrepancies to be reported and if possible, the resident re-weighed for verification. The DON stated she had not been notified Resident #28 had weight discrepancies, and review of the medical record did not show the resident had been re-weighed. The DON was unaware Resident #28 had experienced a 23-pound weight loss since admission on 12/4/2024 (9.96% weight loss in 49 days), until it was brought to her attention during the survey. The DON stated once she was made aware, she notified the Nurse Practitioner (NP) and interventions were put into place. Further interview revealed Resident #28 had not had a functional decline and his plans were to be discharged home next week. The DON stated Resident #28 did not have wounds or active infections and had no negative outcomes. The DON confirmed the facility failed to follow the policy for weight loss. Review of a Registered Dietitian Note for Resident #28 dated 1/23/2025 at 11:40 PM, revealed current weight 208.8 pounds, BMI (body mass index) 28.3; IBWR (ideal body weight range) 160-196 lbs (pounds). Average meal intakes 75-100% with [PHONE NUMBER] ml (milliliters) fluid intake. Supplements and an appetite stimulant were started on 1/23/2025. The resident admitted he had experienced weight loss prior to admission. He was recently hospitalized for porphyria (11/26/2024-12/4/2024). Resident #28's significant weight loss since admission was unavoidable related to diagnosis of porphyria. The resident stated when he consumes more it causes his diarrhea to worsen. During an interview on 1/24/2025 at 9:29 AM, Resident #28 stated he has had intentionally lost weight over the past year. He has been limiting his oral intake to control his fecal incontinence. The fecal incontinence started occurring a few years ago. He had not reported to anyone why he was limiting his oral intake. He stated he feels he has made gains in strength and mobility since being at the facility. He stated staff weigh him weekly, not the same staff every time, but in the same wheelchair. He had no issues with the meals provided, and really enjoyed his sodas. Since being hospitalized his soda intake is much less than what he would normally consume. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 9:50 AM, the NP stated he was notified on 1/23/2025 Resident #28 needed to be evaluated for weight loss since admission. During the evaluation Resident #28 admitted to a history of depression with hospitalization 3 years ago. The resident does appear thinner, but does not look cachectic (physical appearance of a loss of muscle mass), and has not had any negative outcomes. The resident is still above his ideal body weight; and does not have any wounds, edema, or infections. The NP felt Resident #28's weight loss was unavoidable with the recent illness, history of depression, and the resident admitting he is intentionally consuming less to control his fecal incontinence. The NP felt the weight recorded of 177 was an inaccurate recorded weight.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility contract review, medical record review, and interviews, the facility failed to ensure dialysis communications records were completed for 1 resident (Resident #11) of 1 resident reviewed for dialysis. The findings include: Review of the facility's dialysis contract dated 4/5/2013, revealed .facility will provide for the interchange of information useful or necessary for the care of the designated resident . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease (ESRD), Hypertensive Heart and Kidney Disease, and Diabetes. Review of the Physician's Orders for Resident #11 dated 12/13/2024, revealed .Dialysis: check site for bleeding and signs or symptoms of infection [to] R [right] chest every day and night shift .Dialysis: Appointment .Mon [Monday], Wed [Wednesday], Fri [Friday] . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed the resident received dialysis. Review of the comprehensive care plan for Resident #11 dated 12/16/2024, revealed .resident needs dialysis related to ESRD . encourage resident to go for the scheduled dialysis appointments . During an interview on 1/23/2025 at 6:02 PM, Registered Nurse (RN) K stated the dialysis communication records are sent to dialysis with the resident and then are sent back to the facility from the dialysis center. RN K stated when the document returns to the facility from the dialysis center, the nurse should inspect the document to ensure it is filled out completely or call the dialysis center if the form is missing upon the resident's return. Review of the Dialysis Communication Records for Resident #11 dated 12/13/2024 through 1/22/2025, revealed incomplete documentation on the following dates: .1/8/2025 .Pre-RR [respiratory rate] .[blank] . 1/10/2025 Pre-Tp [temperature] .[blank] .Post-Tp .[blank] .Pre-RR .[blank] .Post-RR .[blank] .Pre-Wt [weight] . [blank] .Post-Wt .[blank] .1/15/2025 .Pre-RR .[blank] .Post-RR .[blank] .1/17/2025 .Pre-RR .[blank] .Post-RR . [blank] .1/20/2025 .Pre-RR .[blank] .Post-RR .[blank] . Further review revealed there were no dialysis communication forms available for review on 12/13/2024, 12/16/2024, 12/18/2024, 12/20/2024, 12/23/2024, 12/25/2024, 12/27/2024, 12/30,2024, 1/1/2025, 1/3/2025, 1/6/2025, and 1/13/2025. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 9:05 PM, the Director of Nursing (DON) confirmed the dialysis communication forms for Resident #11 dated 1/8/2025, 1/10/2025, 1/15/2025, 1/17/2025, 1/20/2025 were not filled out completely and the facility failed to ensure the documentation was completed upon the resident's return from dialysis. The DON confirmed the dialysis communication forms for Resident #11 dated 12/13/2024, 12/16/2024, 12/18/2024, 12/20/2024, 12/23/2024, 12/25/2024, 12/27/2024, 12/30,2024, 1/1/2025, 1/3/2025, 1/6/2025, 1/13/2025 were missing and not available for review.

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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. 48100 Based on facility policy review, observation, and interview, the facility failed to ensure medications were secured appropriately on 1 of 2 medication carts observed for medication storage. The findings include: Review of the facility's policy titled, Medication Labeling and Storage, dated 2001 (exact date unknown), revealed .the facility stores all medications and biologicals in locked compartments .only authorized personnel have access to [the] keys .compartments .including .carts .containing medications .are locked when not in use .and .carts used .are not left unattended if open or .available to others . During an observation on 1/23/2025 at 11:30 AM, revealed the 200/300 hall medication cart was stored at the nurses' station, locked, with the medication cart keys present in the outer lock located on the left upper drawer. Further observation revealed the nurse designated to the hall (Licensed Practical Nurse-LPN G) was not present at the nurses' station. There were staff members present on the hall, and no residents were present at the time of the observation. Continued observation revealed LPN D returned to the medication cart with the surveyor at 11:38 AM to retrieve the keys and secure the medication cart. During an interview on 1/23/2025 at 11:39 AM, LPN D stated she was the nurse designated to the medication cart for 200/300 hall. LPN D stated she .forgot to grab the keys . and then placed the keys back on her person after removing the keys from the outer lock of the medication cart. LPN D stated she was to have the medication cart keys secured on her person at all times and confirmed she failed to ensure the medication cart was secured properly. During an interview on 1/23/2025 at 11:48 AM, the Director of Nursing (DON) stated the nurses designated to the medication carts are to store the medication cart keys on their person at all times. The DON confirmed LPN D failed to ensure the medication cart for 200/300 hall was secured properly.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, and interview, the facility failed to maintain an accurate medical record for 1 resident (Resident #11) of 2 residents reviewed for wounds of 4 residents sampled. The findings include: Review of the facility's policy titled, Charting and Documentation, dated 2001 revealed .All services provided to the resident .shall be documented in the resident's medical record .The following information is to be documented in the resident's medical record .Medications administered .Treatments or services performed . Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Fracture of the Right Femur, Encounter for Orthopedic Aftercare, Type 2 Diabetes Mellitus, and End Stage Renal Disease. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #11 was at risk for pressure ulcer/pressure injuries, had a stage 2 pressure ulcer that was not present on admission, 2 unstageable deep tissue injuries that were present on admission and the resident received dialysis. Review of the Order Recap Report for Resident #11 revealed an order dated 12/15/2024 - 12/18/2024, for . cleanse buttock w [with]/NS [normal saline], cover with xeroform [adherent dressing for low drainage wounds] and border gauze, change daily and prn [as needed] . Review of the Wound assessment dated [DATE], revealed Resident #11 acquired a new Stage 2 pressure wound that measured 2.5 centimeters (cm) x (by) 2 cm x 0.1 cm. Review of the Order Recap Report for Resident #11 revealed an order dated 12/17/2024 - 1/3/2025 for . Sacrum: Cleanse with NS, then apply xeroform and then apply border gauze dressing. change daily and PRN . Review of the wound and product specialist note dated 12/19/2024, revealed Resident #11's wound was assessed. It was noted .Body Location .Sacrum .Drainage .Light .Last Debridement Date .12/19/2024 . Wound Type .Decubitus/Pressure Ulcer .Thickness/Stage .Stage 2 .Measurement .2.5/2.0/0.1 .Xerofom . Bordered Gauze . Review of the Wound Assessment for Resident #11 dated 12/27/2024, revealed .Sacrum .Pressure .Stage 3 . Wound Size .Length (cm) .2 .Width (cm) .3 .Depth (cm) .0.1 .Wound progression .Declined .Stage Increased . Yes .Physician notified .Yes . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Skin Pressure Ulcer Weekly documentation for Resident #11 dated 1/3/2025, revealed the resident had a Stage 3 pressure ulcer to the sacrum with measurements of 2 x 1.5 x 0.2 cm. It was noted . MD .aware of wounds . Review of the Order Recap Report revealed an order dated 1/3/2025 - 1/8/2025 for .Sacrum: Cleanse with NS, then apply calcium alginate [highly absorbent dressing used to treat wounds] and then apply border gauze dressing. change daily and PRN . Review of the Skin Pressure Ulcer Weekly documentation dated 1/8/2025, revealed Resident #11 had a sacral pressure ulcer measuring 1.3 x 0.3 cm. It was noted .Reclassified as unstageable d/t [due to] increase amount of slough present to wound bed peri wound present with pink tissue with scar tissue present to sacral area .MD .aware . Review of the Order Recap Report for Resident #11 revealed an order dated 1/8/2025 - 1/15/2025 for . TREATMENT: Cleanse sacrum with NS pat dry, then apply Santyl [ointment used to remove damaged tissue from chronic skin ulcers] to wound bed then apply border gauze dressing. change daily and PRN . Review of the Treatment Administration Record (TAR) dated 1/8/2025 - 1/15/2025, revealed no evidence that Resident #11's sacrum treatment with Santyl was administered on 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, and 1/15/2025. Review of documentation provided by the Director of Nursing (DON) revealed Licensed Practical Nurse (LPN) D was responsible for Resident #11's wound treatment on 1/10/2025, Registered Nurse (RN) I was responsible for Resident #11's wound treatment on 1/11/2025 and 1/12/2025, LPN J was responsible for Resident #11's wound treatment on 1/13/2025, and LPN C was responsible for Resident #11's wound treatment on 1/15/2025. Review of the Skin Pressure Ulcer Weekly documentation for Resident #11 dated 1/15/2025, revealed the resident had a Stage 3 Sacrum pressure ulcer measuring 1 x 0.6 x 0.2 cm. It was noted .Reclassified as Stage 3 upon assessment .beefy red tissue to wound bed peri wound presents with scar tissue to sacral area peri wound .Improving new treatment .in place .MD .aware of wounds . Review of the Order Recap Report for Resident #11 revealed an order dated 1/15/2025 - 1/23/2025 for . TREATMENT: Cleanse sacrum with NS pat dry, then apply Calcium alginate to wound bed then apply border gauze dressing. change daily and PRN . Review of the Nurse Practitioner (NP) PROGRESS NOTE dated 1/23/2025, revealed .Chief Complaint/Nature of Presenting Problem .Evaluation of breakdown to sacrum .past medical history . end-stage renal disease on hemodialysis .anemia .DM2 [Type 2 Diabetes Mellitus] .neuropathy .He was admitted with STDI to his right heel and was later found to have breakdown to his sacrum .Currently being followed by wound care .Sacral breakdown is superficial approximately 1.5x0.2 [cm] .There is no significant drainage. There is no periwound erythema. There is no odor .DIAGNOSIS AND ASSESSMENT .Pressure ulcer, sacrum .PLAN .Meds/labs/notes reviewed .Wounds are healing nicely .Wound care to continue to follow . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/23/2025 at 9:09 AM, the Wound Care Nurse stated wounds were evaluated weekly and any decline or changes are communicated to the provider. The Wound Care Nurse stated she provided the treatment on the day she evaluated the wound and licensed nurses provided daily wound treatments. The Wound Care Nurse reported she did not verify on the TAR that nurses were documenting treatments. During an interview and observation on 1/23/2025 at 5:41 PM, the Wound Care Nurse stated the previous wound care nurse was made aware of new skin breakdown to Resident #11's buttock area on 12/15/2024 and obtained an order to cleanse with normal saline, apply xeroform, and cover with border dressing daily and PRN. The Wound Care Nurse evaluated the wound on 12/17/2024 and was identified as a Stage 2 pressure ulcer to the sacrum and continued the treatment. The wound was evaluated by the Wound Care Nurse on 12/27/2024 and had declined to a Stage 3 and the treatment order was changed to calcium alginate with border dressing daily. Resident #11's wound was evaluated again on 1/3/2025 and the treatment remained the same. On the 1/8/2025, evaluation the wound had declined to an unstageable wound due to increased slough to wound bed with pink tissue to periwound area. The Nurse Practitioner (NP) was notified and the treatment was changed to cleanse with normal saline, pat dry, apply Santyl to the wound bed and apply border gauze. The Wound Care Nurse administered the treatment on 1/8/2025. Resident #11's TAR was reviewed with the Wound Care Nurse. The Wound Care Nurse stated she was unaware treatments had not be performed on 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, and 1/15/2025. Resident #11's wound was evaluated on 1/15/2025 and it had improved back to a Stage 3 and the wound treatment was changed to cleanse with NS pat dry, apply calcium alginate to wound bed then apply border gauze dressing daily and prn. Santyl was no longer necessary because there was no slough to wound bed. The Wound Care Nurse and the NP evaluated Resident #11's sacrum wound on 1/23/2025 and it had improved to a Stage 3 measuring 1.5 x 0.2 x 0.1 cm and the treatment was changed to cleanse with normal saline, apply zinc oxide, and cover with dry border dressing daily and PRN due to the wound now being superficial. During an observation and interview on 1/23/2025 at 6:40 PM, Resident #11's TAR was reviewed with the DON. The DON stated according to the TAR the order dated 1/8/2025 to cleanse the sacrum with NS pat dry, then apply Santyl to wound bed then apply border gauze dressing daily was not completed according to the physician's order on 1/10/2025, 1/11/2025, 1/12/2025, 1/13/2025, and 1/15/2025. The DON stated according to wound documentation the wound had improved and had not declined. During an interview on 1/23/2025 at 9:19 PM, Resident #11 stated staff performed wound care .it seems like every day . to his sacrum. During an observation with the Wound Care Nurse, in Resident #11's room, on 1/23/2025 at 9:31 PM, revealed Resident #11's wound was consistent with the wound evaluation performed by the Nurse Practitioner and the Wound Care Nurse on 1/23/2025 with no concerns noted. During an interview on 1/24/2025 at 9:40 AM, the NP stated he observed wounds upon admission and every 30 days. The NP tracked the weekly progress of wounds. The NP stated he was unable to say if Resident #11 received the treatment with Santyl that was ordered from 1/8/2025 - 1/15/2025 or if it was a documentation error. On 1/8/2025 the sacral wound declined to unstageable with increased slough. On 1/15/2025- the wound was reclassified as stage 3. The wound improved from 1/8/2025 - 1/15/2025. The NP stated it was his expectation that wound care orders were followed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellpark at Shannondale	7512 Middlebrook Pike Knoxville, TN 37909

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/24/2025 at 11:05 AM, LPN C stated she had been responsible for Resident #11's wound care on 1/15/2025 and had provided Santyl treatment to the resident's sacrum but did not document it. During an interview on 1/24/2025 at 11:25 AM, LPN D stated she had been responsible for Resident #11's wound care on 1/10/2025 and had provided the Santyl treatment to the resident's sacrum. LPN D stated she was unaware why she had not documented the treatment on the TAR and stated she must have gotten busy or forgot. During a telephone interview on 1/24/2025 at 11:58 AM, RN I stated she had been responsible for Resident #11's wound care on 1/11/2025 and 1/12/2025 and had provided the Santyl treatment to the resident's sacrum and .I probably forgot to document it . Attempted telephone interview with LPN J on 1/24/2025 at 12:06 PM. During an interview on 1/24/2025 at 1:01 PM, the DON confirmed it was her expectation that treatments were documented in the medical record accurately and physician's orders were followed.

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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, medical record review, observations, and interviews, the facility failed to implement Enhanced Barrier Precautions (EBP) for 1 resident (Resident #10) and failed to identify the need for EBP for 1 resident (Resident #34) of 5 residents reviewed for EBPs. The facility failed to offer hand hygiene during meal service to 5 residents (Residents #22, #134, #135, #11, and #136) on 1 of 3 halls observed for meal service. The findings include: Review of the facility's policy titled, Preparing the Resident for a Meal, revised on 9/2010, revealed . Encourage the resident to wash his or her face and hands. Assist as needed . Review of the facility's policy titled, Enhanced Barrier Precautions, dated 8/2022, revealed .Enhanced barrier precautions .are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents .EBP are used as an infection prevention and control intervention .gloves and gown are applied prior to performing high contacted resident care activity .changing linens .EBPs are indicated .for residents with wounds . indwelling medical devices .signs are posted in [on] the door .indicating the type of precautions and PPE [personal protective equipment] required. Review of the facility's policy titled, Handwashing/Hand Hygiene, revised on 10/2023, revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections . Personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections .Residents .are encouraged to practice hand hygiene . Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Encounter for Surgical Aftercare, Pressure Ulcer of the Sacral Region, and Neuromuscular Dysfunction of Bladder. Review of a Physician's Order for Resident #10 dated 12/10/2024, revealed .Enhanced Barrier Precautions r/t [related to]: sacral wound/foley [medical device that drains urine from the bladder]/ostomy [surgical skin opening] . Review of the 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #10 had an indwelling catheter, ostomy, and 1 Stage 4 Pressure Ulcer that was present on admission. During an observation on 1/21/2025 at 11:25 AM, there was a sign posted on the outside of Resident #10's door that stated ENHANCED BARRIER PRECAUTIONS .PROVIDERS AND STAFF MUST .Wear gloves and a gown for the following High-Contact Resident Care Activities .Changing Linens . Continued observation revealed there was a plastic bin with drawers that contained PPE. During an observation on 1/21/2025 at 12:43 PM, Certified Nursing Assistant (CNA) F was observed in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #10's room changing Resident #10's bed linens. CNA F wore gloves during the linen change and did not wear a gown. CNA F changed the bed linens and bagged the linens, doffed (removed) the gloves, sanitized the hands, and exited the room. During an interview on 1/21/2025 at 12:50 PM, CNA F stated Resident #10 was on Enhanced Barrier Precautions for wounds, colostomy, and urinary catheter. CNA F confirmed she changed Resident #10's bed linens and stated a gown and gloves were only required while providing direct patient care. This surveyor pointed to the sign posted on the resident's door that indicated gloves and gown were required while changing bed linens. CNA F stated .I wasn't doing personal care, so a gown was not required . During an interview on 1/21/2025 at 3:59 PM, the Director of Nursing (DON)/ Infection Preventionist (IP) confirmed a gown and gloves were required for bed linen changes for a resident on EBP. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy (chemical imbalance in the blood which affects the brain), Cellulitis, and Depression. Review of the comprehensive care plan for Resident #34 dated 1/14/2025, revealed .pressure ulcer on bilateral posterior thighs . Review of a Skin Pressure Ulcer Weekly assessment for Resident #34 dated 1/15/2025, revealed the resident had 2 pressure ulcers upon admission. Review of the Physician's Orders for Resident #34 dated 1/15/2025, revealed .Skin Prep [the process of cleaning and disinfecting the skin] to R [right] thigh BID [twice a day] .Apply zinc oxide [barrier cream] to L [left] thigh BID . Further review revealed no physician order present for EBPs due to open wounds (pressure ulcers to bilateral thighs). Review of an admission MDS assessment dated [DATE], revealed the assessment was in progress for Resident #34. During an observation and interview on 1/22/2025 at 9:00 AM, revealed there was no EBP signage posted on the outside of Resident #34's door and no PPE readily available for staff use. LPN C stated Resident #34 had open pressure wounds present thighs. LPN C was asked if Resident #34 should have been placed in EBP for the pressure wounds to bilateral thighs, LPN C replied I guess so .yes . LPN C confirmed there was no EBP signage on Resident #34's door to alert staff of the need to implement EBP. During an interview on 1/22/2025 at 9:15 AM, the DON/ IP stated it was her expectation when a resident had a chronic wound that required treatments, the resident should be placed in EBP. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Left Femur Fracture, Fracture of the Lower End of Left Radius and Ulna, and Hypertension. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS assessment dated [DATE], revealed Resident #22 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #22 required supervision or touching assistance with eating and partial/moderate assistance with personal hygiene. Review of the comprehensive care plan for Resident #22 dated 1/21/2025, revealed .ADL [activities of daily living] Self Care Performance Deficit .Assist resident at level needed to complete adl tasks . During an observation on 1/21/2025 at 12:26 PM, [NAME] H delivered the lunch meal tray to Resident #22 in the resident's room. [NAME] H set up the meal tray for Resident #22 and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #134 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Anxiety, and Depression. Review of the Functional Abilities assessment for Resident #134 dated 1/12/2025, revealed the resident required substantial/maximal assistance for personal hygiene and setup or clean-up assistance for eating. Review of the BIMS assessment for Resident #134 dated 1/13/2025, revealed the resident scored a 14 which indicated the resident was cognitively intact. Review of the comprehensive care plan for Resident #134 dated 1/21/2025, revealed .ADL Self Care Performance Deficit r/t [related to] weakness, debility .Assist resident .to complete adl tasks . During an observation on 1/21/2025 at 12:27 PM, [NAME] H delivered the meal tray to Resident #134 in the resident's room room. [NAME] H assisted the resident to set up the meal tray and exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #135 was admitted to the facility on [DATE] with diagnoses including Osteoarthritis, Diabetes, and Morbid Obesity. Review of the comprehensive care plan for Resident #135 dated 1/13/2025, revealed .ADL Self Care Performance Deficit r/t recent surgery .perform adl's with assistance of staff . Review of the BIMS assessment for Resident #135 dated 1/14/2025, revealed the resident scored a 15 which indicated the resident was cognitively intact. Review of the Functional Abilities assessment for Resident #134 dated 1/15/2025, revealed the resident required supervisor or touching assistance for personal hygiene and setup or clean-up assistance for eating. During an observation on 1/21/2025 at 12:29 PM, LPN G delivered the meal tray to Resident #135 in the resident's room. LPN G set up the meal tray and exited the room without offering hand hygiene assistance to the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Unsteadiness on Feet, Edema, and Diabetes. Review of the admission MDS assessment dated [DATE], revealed Resident #11 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Resident #11 required setup or clean up assistance with eating and supervision or touching assistance with personal hygiene. Review of the comprehensive care plan for Resident #11 revised 1/21/2025, revealed .ADL Self Care Performance Deficit .Assist resident at level needed to complete adl tasks . During an observation on 1/21/2025 at 12:30 PM, [NAME] H delivered the meal tray to Resident #11 in the resident's room. [NAME] H exited the room without offering hand hygiene assistance to the resident. Review of the medical record revealed Resident #136 was admitted to the facility on [DATE] with diagnoses including Obesity, Diabetes, and Muscle Weakness. Review of the comprehensive care plan for Resident #136 dated 1/2/2025, revealed .ADL Self Care Performance Deficit .Assist resident at level needed to complete adl tasks . Review of the admission MDS assessment dated [DATE], revealed Resident #136 scored a 15 on the BIMS assessment which indicated the resident cognitively intact. Further review revealed Resident #136 required supervision or touching assistance with eating and partial/moderate assistance with personal hygiene. During an observation on 1/21/2025 at 12:31 PM, LPN G delivered the meal tray to Resident #136 in the resident's room. LPN G donned gloves and gown to deliver the meal tray and exited the room without offering hand hygiene assistance to the resident. During an interview on 1/21/2025 at 12:38 PM, LPN G stated residents were to be offered hand hygiene assistance prior to meals using hand sanitizer. LPN G confirmed she had not offered hand hygiene assistance to Resident #135 and Resident #136. During an interview on 1/21/2025 at 12:41 PM, [NAME] H stated she was unaware if hand hygiene was supposed to be offered to residents prior to meals. [NAME] H confirmed she had not offered hand hygiene assistance to Resident #22, Resident #134, and Resident #11. During an interview on 1/21/2025 at 1:22 PM, the DON/IP confirmed the staff were to offer hand hygiene assistance to the residents prior to meals.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, Centers for Disease Control and Prevention (CDC) recommendations, medical record review, and interview, the facility failed to offer COVID-19 immunizations according to CDC recommendations and facility policy for 3 residents (Residents #10, #134, and #139) of 5 residents reviewed for immunizations. The findings include: Review of the facility's policy titled, Immunizations - Residents, reviewed/revised on 7/2023, revealed .It is the policy of this facility to offer and administer .COVID-19 immunization to eligible residents .Residents will be screened at the time of admission to determine vaccine status and eligibility using current CDC . guidelines, to receive the .COVID-19 vaccine(s) . Review of the Centers for Disease Control and Prevention (CDC) documentation titled, Staying Up to Date with COVID-19 Vaccines, dated 1/7/2025, revealed .Who needs a COVID-19 vaccine .Everyone ages 6 months and older should get the 2024-2025 COVID-19 vaccine. This includes people who have received a COVID-19 vaccine .Importance of staying up to date .Getting the 2024-2025 COVID-19 vaccine is important because .Protection from the COVID-19 vaccine decreases over time .Immunity after COVID-19 decreases with time .COVID-19 vaccines are updated to give you the best protection from the currently circulating strains .Getting the 2024-2025 COVID-19 vaccine is especially important if you .Are ages [AGE] years and older .Are living in a long-term care facility .When are you up to date? .People ages [AGE] years and older . You are up to date when you have received .2 doses of any 2024-2025 COVID-19 vaccine 6 months apart . While it is recommended to get 2024-2025 COVID-19 vaccine doses 6 months apart, the minimum time is 2 months apart . Review of the medical record revealed Resident #10 was admitted to the facility 11/4/2024 with diagnoses including Encounter for Surgical Aftercare Following Surgery on the Digestive System, Acute Respiratory Failure, and Unsteadiness on Feet. Review of the medical record for Resident #10 revealed, the resident received a COVID-19 vaccine on 3/30/2021. Continued review revealed Resident #10 had not been offered or screened for eligibility to receive a COVID-19 vaccine while at the facility. Review of the medical record revealed Resident #134 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Acute Respiratory Failure. Review of the medical record for Resident #134 revealed the resident received a COVID-19 vaccine on 10/27/2022. Continued review revealed Resident #134 had not been offered or screened for eligibility to receive a COVID-19 vaccine while at the facility. Review of the medical record revealed Resident #139 was admitted to the facility on [DATE] with diagnoses including Fracture of the Lower End of the Tibia, Fracture of the Upper and Lower End of the Right Fibula, Encounter for Orthopedic Aftercare, and Chronic Obstructive Pulmonary Disease. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #139 revealed the resident received a COVID-19 vaccine on 3/17/2022. Continued review revealed Resident #139 had not been offered or screened for eligibility to receive a COVID-19 vaccine while at the facility. During an interview on 1/24/2025 at 9:14 AM, the Director of Nursing (DON) stated she reviewed residents' vaccination history from the Tennessee Department of Health vaccination database on admission and offered COVID-19 vaccinations only to residents that had never received a vaccination. The DON confirmed the facility's policy was to offer vaccinations according to CDC recommendations. The DON reviewed the CDC recommendations and confirmed the current recommendations were for adults over the age of 65 to receive the COVID-19 vaccine every 6 months. The DON stated the facility had been using the recommendations from 2021. The DON confirmed Residents #10, #134, and #139 should have been offered and screened for COVID-19 vaccine eligibility due to not receiving a vaccine in the last 6 months and the facility's policy for COVID-19 had not been followed.