

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Stones River Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Haynes Drive Murfreesboro, TN 37129	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure care and services were provided when a Percutaneous Endoscopic Gastrostomy (PEG) tube (a tube inserted into the stomach to administer medications and food supplements through) dressing change was not completed as ordered for 1 of 1 (Resident #20) resident reviewed for the use of an enteral feeding. The findings include: 1. Review of the facility policy titled, Gastrostomy/Jejunostomy Site Care, dated 2001, revealed .The purpose of this procedure are [is] to promote cleanliness and to protect the gastrostomy or jejunostomy site from irritation, breakdown and infection .Verify that there is a physician's order .gently clean the area immediately surrounding the tube .The person performing this procedure should record the following information .The date and time the procedure was performed .if the resident refused .2. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE], with diagnoses including Protein-Calorie Malnutrition, Aphasia, and Dementia. Review of the Physician's Orders dated 5/29/2025, revealed .Change peg tube drain sponge daily. Cleanse base of tubing and stoma [surgically created opening] with normal saline, pat dry and apply new sponge. May secure with paper tape if needed. Every day shift for Peg site care .Review of the care plan dated 6/2/2025, revealed .The resident requires tube feeding r/t [related to] Dysphagia [difficulty swallowing] and not eating, Check for tube placement and gastric contents/residual volume per facility protocol and record, Keep HOB [head of bed] elevated as ordered. Change dressing to peg tube as ordered .Review of the admission Minimal Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score was unable to be assessed due to severe impairment for daily decision making. Resident #20 was assessed to have a PEG tube. Review of the June 2025 Medication Administration Record (MAR) dated 6/1/2025 through 6/30/2025, revealed the dressing change was completed every day in June; specifically, June 26, 27, 28, 29, and 30, 2025. Observation on 6/30/2025 at 9:53 AM, revealed Resident #20 was lying in bed and the dressing on the peg site was dated 6/26/2025. During an interview on 6/30/2025 at 11:14 AM, Registered Nurse (RN) A confirmed that Resident #20's dressing was dated 6/26/2025 and should have been changed daily. During an interview on 6/30/2025 at 11:16 AM, the Director of Nursing (DON) was asked if there was an order to change a PEG dressing daily, should this have been done daily. The DON stated, Yes. The DON was asked if a dressing was dated 6/26/2025, but the MAR showed that it had been completed on 6/27, 6/28, 6/29, and 6/30 (2025), would that be accurate documentation. The DON stated, That is considered an error.</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Stones River Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Haynes Drive Murfreesboro, TN 37129	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Stones River Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Haynes Drive Murfreesboro, TN 37129	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on policy review, kitchen sanitation logs, refrigerator and dishwasher temperature logs, observation, and interview, the facility failed to ensure food was served under sanitary conditions when the kitchen floor was dirty with a black sticky substance, the deep fryer had thick sticky yellow dried coating on the outside, the steam table had dried brown streaks, the ice machine had a black dried substance on the inside, and undated items were in the refrigerator. The facility had a census of 27 with 26 of those residents receiving a tray from the kitchen. The findings include: 1. Review of the facility policy titled, Sanitization, revised October 2008, revealed .The food service area shall be maintained in a clean and sanitary manner.Dishwashing machines must be operated using the following specifications .High-Temperature Dishwasher .Wash temperature (150 [degrees]-165 F [Fahrenheit]) .Rinse temperature (165 -180 F) .Ice machines and ice storage containers will be .cleaned, and sanitized per manufacturer's instructions and facility policy.Kitchen and dining room surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime. Review of the facility policy titled, Dishwashing Machine Use, revised March 2010, revealed .The operator will check temperatures using the machine gauge with each dishwashing machine cycle, and will record the results in a facility approved log. The operator will monitor the gauge frequently during dishwashing machine cycle. Inadequate temperatures will be reported to the supervisor and corrected immediately.If the hot water temperatures .do not meet requirements, cease use of dishwashing machine immediately until temperatures .are adjusted. Review of the facility policy titled, Refrigerators and Freezers, revised December 2014, revealed .employees will check and record refrigerator and freezer temperatures daily with first opening and closing in the evening.Received dates.will be marked on cases and on individual items.'Use by' dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and 'use by' dates indicated once food is opened.Supervisors will be responsible for ensuring food items .are not expired or past perish dates . Review of the facility policy titled, Food Receiving and Storage, revised July 2014, revealed .All foods stored in the refrigerator or freezer will be covered, labeled and dated.Beverages must be dated when opened and discarded after twenty-four (24) hours.Other opened containers must be dated. 2. Review of the Weekly Ice Machine Inspection, revealed Ice Machine is Whiped [wiped] clean Every Day. Dietary & Maint [maintenance] will share this responsibility. Date & Initial after cleaning .Clean Bin .Door Seal .Ice Shoot [chute] . The weeks of 4/20/2025, 4/27/2025, 5/11/2025, 5/18/2025, 6/8/2025, 6/15/2025, and 6/23/2025 had not been dated or initialed. Review of the DIETARY CLEANING CHART June 23-29, 2025, revealed that it was not initialed for cleaning of the food preparation tables, sinks, or carts on Wednesday (6/25/2025) or Saturday (6/28/2025). The log was not initialed for June 23-28 for the steam table, dish machine, oven stove tops, refrigerators, microwave, ice machine, corn meal, flour, and sugar bins, stock room, cooler and freezer. 3. Review of the DISH MACHINE TEMP. [Temperature] CHART, dated June 2025, revealed temperatures were not recorded for supper on 6/11/2025, 6/12/2025, 6/19/2025, 6/20/2025, and 6/26/2025. There were no temperatures recorded for breakfast on 6/29/2025. There were no temperatures recorded for breakfast or lunch on 6/23/2025 and 6/28/2025. There were no temperatures recorded for breakfast, lunch, or supper on 6/27/2025. There were no initials in the Supervisor Initial column for the entire month. Review of the TEMPERTURE READING FOR DIETARY FREEZERS AND REFRIGERATORS, dated June 2025, revealed there were no temperature readings recorded for the Walk-In Cooler, Main Kitchen Refrigerator, South Refrigerator, North Refrigerator and Kitchen Freezer for 6/17/2025. There were no initials in the Superv [Supervisor] Initials column for the entire month. 4. Observation in the kitchen on 6/29/2025 at 10:25 AM, revealed: a. the kitchen floor with black slick areas throughout b. the steam table with dried brown streaks on the side c. the deep fryer with a thick sticky yellow dried coating on the outside d. the wall behind the deep fryer with dried yellow splatter e. the walk-in freezer with 2-13 x (by) 9 pans of undated sweet rolls f. 5 storage bags of sausage balls that were undated g. the walk-in refrigerator contained 1 bottle of chocolate syrup with no open date and 1 container of vegetable base with an open date of 4/30 h. the reach in refrigerator contained 1 opened box of grape juice, 1 opened box of cranberry juice, 1 opened box of apple juice and 1 opened box of prune juice with no open dates Observation in the kitchen on 6/29/2025 at 10:25 AM, revealed the dishwasher rinse temperature only reached 120 degrees. The sticker on the Rinse gauge showed it should rinse at 180 degrees. Dietary Aide B verified the rinse temperature of 120 degrees. Dietary Aide B was asked if the dishwasher was a high temperature washer and if it should be 180 degrees. She</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445534	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025
NAME OF PROVIDER OR SUPPLIER Stones River Manor, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 205 Haynes Drive Murfreesboro, TN 37129	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on policy review, the facility's Infection Control documents, and interview, the facility failed to follow Infection Control practices when they failed to track pathogens (a bacteria, virus, or other microorganism that can cause disease) in the monthly .Infection Control 2025 report which could potentially affect 27 out of 27 Residents. The findings include: 1. Review of the facility's policy titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated 12/2016, revealed .Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form.All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include.pathogen identified.date of culture. 2. Review of the monthly .Infection Control 2025 report dated 3/2025, 4/2025, and 5/2025, revealed .ROOM.PATIENT.admit date .S/S [signs/symptoms] START DATE.LAB TESTING AND RESULTS.TX [treatment] START.TX STOP. DIAGNOSES.TREATMENT ORDERS.IN HOUSE.COMM. [community] ACQUIRED. There was no column on the .Infection Control 2025 report that named the pathogen that was being tracked. During an interview on 7/1/2025 at 9:05 AM, the Infection Preventionist/Director of Nursing confirmed that she does not track the pathogen in the monthly .Infection Control 2025 reports.</p>		