STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	44E480	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bledsoe County Nursing Home	107 Wheelertown Avenue Pikeville, TN 37367

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on interview, record review, and facility policy review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 4 (Residents #3, #6, #12, and #23) of 4 sampled residents reviewed for resident assessment. Findings included:A facility policy titled, MDS Assessment Coordinator, revised 11/2019, indicated, 3. Each individual who completes a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by: a. dating and signing the assessment (MDS); and b. identifying each section completed. 1. An admission Record revealed the facility admitted Resident #23 on 08/02/2009. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus with hyperglycemia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/10/2026, revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated the resident received one insulin injection during the last seven days and had no orders for insulin.Resident #23's Order Recap Report for the timeframe 06/01/2023 - 05/31/2026, revealed no evidence of a physician order for the resident to be administered insulin. During an interview on 05/07/2026 at 11:00 AM, the MDS Coordinator reviewed Resident #23's medical record and stated Resident #23's quarterly MDS with an ARD of 04/10/2026 was coded incorrectly as the resident had never been ordered insulin.During an interview on 05/07/2026 at 1:28 PM, the Director of Nursing (DON) stated Resident #23 was never ordered insulin, and the MDS was coded incorrectly. During an interview on 05/07/2026 at 3:24 PM, the Administrator stated accuracy was the overall goal of the completion of the MDS and deferred the specifics of the error to the DON. 2. An admission Record revealed the facility admitted Resident #3 on 08/18/2025. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus without complications. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/31/2025, revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received one insulin injection during the last seven days and had no orders for insulin. A quarterly MDS, with an ARD of 12/01/2025, revealed Resident #3 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received one insulin injection during the last seven days and had no orders for insulin.A quarterly MDS, with an ARD of 03/03/2026, revealed Resident #3 had a BIMS score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received one insulin injection during the last seven days and had no orders for insulin. Resident #3's Order Recap Report, for the timeframe 12/01/2025 - 05/31/2026, revealed no evidence of a physician order for the resident to be administered insulin. During an interview on 05/07/2026 at 1:29 PM, the Director of Nursing stated there was no insulin ordered for Resident #3. 3. An admission Record revealed the facility admitted Resident #12 on 05/18/2007. According to the admission Record, the resident had a medical history that included a diagnosis of personal history of transient ischemic attack.An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/11/2026, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. The MDS indicated the resident received an anticoagulant medication during the last seven days. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #12's Order Recap Report, for the timeframe 12/01/2025 - 05/31/2206, revealed no evidence of a physician order for the resident to be administered an anticoagulant medication. During an interview on 05/06/2026 at 9:24 AM, the MDS Coordinator stated Resident #12's annual MDS with an ARD of 04/11/2026 was coded incorrectly as the resident was never prescribed or administered an anticoagulant medication. During an interview on 05/07/2026 at 1:29 PM, the Director of Nursing (DON) stated Resident #12 was not on anticoagulant medication. Per the DON, she expected the MDS to be accurate. During an interview onˆ05/07/2026 at 3:24ˆPM, the Administratorˆstatedˆaccuracyˆwasˆthe overall goalˆofˆthe completion of the MDS andˆdeferred the specifics of the error to the DON. 4. An admission Record revealed the facility admitted Resident #6 on 06/12/2018. According to the admission Record, the resident had a medical history that included a diagnosis of dementia and type 2 diabetes mellitus. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/13/2026, revealed Resident #6 had a Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDSˆindicatedˆthe resident receivedˆoneˆinsulinˆinjection during the last seven days and had no orders for insulin. Resident #6's Medication Administration Record for the timeframe 03/01/2026 - 03/31/2026, revealed no evidence to indicate the resident was administered insulin. During an interview on 05/07/2026 at 2:45 PM, the MDS Coordinator reviewed Resident #6's annual MDS with an ARD of 03/13/2026 and stated the MDS had been coded to indicate the resident received insulin; however, the resident did not. During an interview on 05/07/2026 at 1:28 PM, the Director of Nursing (DON) reviewed Resident #6's medical record and stated the resident had no orders for insulin during the MDS lookback period. The DON stated the MDS should not have been coded to indicate the resident received an insulin injection. During an interview onˆ05/07/2026 at 3:24ˆPM, the Administratorˆstatedˆaccuracyˆwasˆthe overall goalˆofˆthe completion of the MDS andˆdeferred the specifics of the error to the DON.ˆˆ

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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. Based on observation, interview, record review, and facility policy review, the facility failed to ensure there was a physician's order and a care plan for dialysis for 1 (Resident #18) of 1 sampled resident reviewed for dialysis. Findings included: A facility policy titled, Hemodialysis, implemented 07/30/2021, revealed, The facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental and psychosocial needs of residents receiving hemodialysis. Per the policy, 12. The facility will ensure that the physician's orders for dialysis include: a. The type of access for dialysis and location; b. The dialysis schedule; c. The nephrologist name and phone number; d. The dialysis facility name and phone number; e. Transportation arrangements to and from the dialysis facility; f. Any medications administration or withholding of specific medications prior to dialysis treatments; g. Any fluid restriction if ordered by the physician. An admission Record revealed the facility admitted Resident #18 on 05/16/2025. According to the admission Record, the resident had a medical history that included diagnosis of end stage renal disease and dependence on renal dialysis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/01/2026, revealed Resident #18 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident received dialysis. Resident #18's Care Plan Report included a focus area initiated 10/18/2019 and canceled 04/09/2026, that indicated the resident received dialysis three times a week. Resident #18's Order Recap Report, for the timeframe 05/01/2025 - 05/31/2026, revealed no evidence of a physician order for the resident to receive dialysis. During a concurrent observation and interview on 05/05/2026 at 11:32 AM, Resident #18 stated they went to dialysis three times a week. The surveyor noted the resident had a bandage over their dialysis port on their upper left arm. During an interview on 05/06/2026 at 2:02 PM, Licensed Practical Nurse (LPN) #1 stated the facility had one resident who was currently on dialysis.ˆLPN #1 stated there should be a physician's order for dialysis in the resident's medical record. LPN #1 reviewed Resident #18's physician's orders and stated she was not able to locate a physician's order for dialysis. LPN #1 stated she thought it was on the care plan, but after looking she was unable to find it on the care plan. During an interview on 05/07/2026 at 1:58 PM, the Administrator stated he expected for there to be a physician's order for residents who received dialysis. During an interview on 05/07/2026 at 3:23 PM, the Director of Nursingˆstated there should be a physician's order in the resident's medical record for dialysis and it should be included on the resident's care plan.ˆ