STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445128	A. Building B. Wing	11/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Oak Ridge	300 Laboratory Rd Oak Ridge, TN 37831

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 49568 Based on facility policy review, medical record review, observation, and interview the facility failed to protect the resident's rights for 1 resident (Resident #20) of 53 residents reviewed. The findings include: Review of the facility policy titled, Resident Rights, revised 11/2017, showed .We strive to cultivate and sustain an excellent quality of life for each individual .by honoring and supporting each patient/resident's preferences, choices, values, and beliefs. Resident #20 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Diabetes Mellitus. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #20 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated the resident was cognitively intact and a bed and chair alarm was used. Review of the comprehensive care plan dated 10/24/2023, showed .Falls .At risk for falls and injury related to falls as evidenced by: Hx [history] of fall, impaired hearing & [and] vision, requires extensive assist w [with]/transfers and ADLs [activities of daily living] . difficulty in walking, muscle weakness, unsteadiness on feet .Sensor Alarm to chair/bed .Educated resident on using chair sensor alarm and not turning alarm off for safety. Resident states I will continue to turn alarm off . During an observation and interview on 11/27/2023 at 10:30AM, in Resident #20's room showed the resident lying in bed with a bed alarm in place. The resident stated she did not like the bed alarm. During an observation and interview on 11/27/2023 at 2:00PM, in the resident's room showed the resident sitting in a wheelchair with a chair alarm in place. The resident stated .I hate this bed and chair alarm .they are annoying .I just turn them off .I don't want them . During an interview on 11/28/2023 at 3:15 PM, Licensed Practical Nurse (LPN) #2 stated she was familiar with Resident #20 and cared for the resident routinely. She also stated the resident removed the bed and chair alarms frequently and the resident had expressed she did not want the alarms in place. (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 11/28/2023 at 3:20 PM, Certified Nursing Assistant (CNA) #1 stated she was familiar with Resident #20 and cared for the resident routinely. She also stated the resident turned the bed and chair alarms off. CNA #1 stated the resident did not want the alarms in place and she informed the resident .it was for her safety . During an observation on 11/29/2023 at 7:50AM, in the resident's room showed the chair alarm was activated and the resident was able to deactivate the alarm. During an interview on 11/29/2023 at 8:00AM, CNA #2 stated she was familiar with Resident #20 and cared for the resident routinely. She also stated the resident had a bed and chair alarm, the resident did not like the alarms, and the resident was able to remove and/or deactivate the alarms. During an interview on 11/29/2023 at 8:05AM, LPN #3 stated she was familiar with Resident #20 and the resident had a bed and chair alarm in place. She also stated the resident hated the sound of the alarms and removed the alarms frequently. During an interview on 11/29/2023 at 1:15PM, LPN #1 stated Resident #20 was weak and unsteady, had a bed and chair alarm in place, and the alarms were placed to prevent falls. LPN #1 confirmed the resident was alert/orientated, was able to voice her wants/needs, and it was a violation of Resident #20's rights to have the alarms in place if the resident had expressed, she did not want the alarms. During an interview on 11/29/2023 at 1:15PM, the Director of Nursing (DON) stated she was not aware Resident #20 did not want the bed and chair alarm in place. The DON confirmed the resident had the right to refuse the bed and chair alarm and the facility violated the resident's rights.

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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** 48100 Based on facility policy review, medical record review, and interview, the facility failed to revise the comprehensive care plan after an anti-anxiety medication was added for 1 resident (Resident #78) of 24 residents reviewed for care plans. The findings include: Review of the facility policy titled, Patient Care Plans, dated 11/2023, showed .New problems are handled as they arise and are to be added to the current care plan . Resident #78 was admitted to the facility on [DATE] with diagnoses including Bipolar Disorder, Anxiety, and Depression. Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], showed Resident #78 scored 99 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had been unable to complete the interview, and received anti-depressant and anti-psychotic medications. Review of Resident #78's comprehensive care plan revised 9/28/2023, showed .Mood state: potential alteration in related to: Bipolar .depression .Administer medications as ordered-Vraylar [anti-psychotic medication] .Administer Fluoxetine [anti-depressant medication] per orders . Review of a Psychiatric Provider Note dated 10/27/2023, showed .Resident [Resident #78] was seen for medication management of: unspecified depression .reported that she [Resident #78] feels anxious all the time .resident requested something for anxiety .start trial of Buspirone for anxiety . Review of the current physician recapitulation orders dated 11/29/2023, showed Fluoxetine 40 milligram (mg) daily, Vraylar 3mg at bedtime and Buspirone (anti-anxiety medication) 5mg twice daily (11/3/2023). Review of the Medication Administration Record (MAR) dated 11/1/2023-11/29/2023, showed Resident #78 had received Buspirone 29 of 29 days. During an interview on 11/28/2023 at 2:38 PM, the Lead MDS Coordinator stated after new psychotropic medications are added, the care plan should be updated at the time the new order is confirmed. The Lead MDS Coordinator confirmed the comprehensive care plan had not been updated for Resident #78 after an anti-anxiety medication was added on 11/3/2023.

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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** 48100 Based on facility policy review, medical record review, and interview, the facility failed to follow a physician's order related to blood glucose monitoring for 1 resident (Resident #58) of 3 residents reviewed for routine blood glucose monitoring. The findings include: Resident #58 was admitted to the facility on [DATE] with diagnoses including End Stage Renal Disease, Type 2 Diabetes Mellitus, and Anemia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #58 scored 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had moderate cognitive impairment and received insulin. Review of Resident #58's comprehensive care plan revised 10/3/2023, showed .Potential alteration in gastrointestinal issues r/t [related to]: Diabetes Mellitus type II with hyperglycemia, long term use of insulin . Administer insulin as ordered . Review of the physician recapitulation orders dated 11/28/2023, showed .Insulin lispro .insulin pen Per Sliding Scale .Twice A Day .If Blood Sugar is greater than 400, give 12 Units and recheck in 1 hour. If continued greater than 400, call [provider] for additional orders . Review of the Medication Administration Record (MAR) dated 11/1/2023-11/28/2023, showed on 5 days (11/1/2023, 11/4/2023, 11/10/2023, 11/12/2023, and 11/22/2023) of 28 days reviewed, blood sugar readings were over 400 and the blood sugar had not been rechecked. During an interview on 11/29/2023 at 9:38 AM, the Director of Nursing (DON) stated it was her expectation the physician orders are followed. The DON confirmed Resident #58's blood sugar was not rechecked per physician orders on 11/1/2023, 11/4/2023, 11/10/2023, 11/12/2023, and 11/22/2023. During an interview on 11/29/2023 at 9:33 AM, the Nurse Practitioner (NP) confirmed Resident #58's blood glucose had not been rechecked as ordered. The NP stated there had not been any adverse outcome to the resident from this deficient practice.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568 Based on facility policy review, observation, and interview the facility failed to properly secure medications for 1 resident (Resident #3) of 96 residents reviewed. The findings include: Review of the facility policy titled Self -Administration of Medications, revised 1/1/2019, showed .If the resident desires to self-administer medications, an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility .If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted .medications of resident .are stored in central medication cart or medication room . Resident #3 was admitted to the facility on [DATE] with diagnoses including Multiple Sclerosis, Dysphagia (difficulty swallowing), Hypertension, and Peripheral Vascular Disease. Review of the Physician Orders showed .Start Date .01/25/2023 .Flonase Allergy Relief (medication used to treat allergies) .spray .50 mcg [microgram] .1 spray in each nostril Twice A Day . Review of a quartlery Minimum Data Set (MDS) assessment dated [DATE], showed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resdient was cognitively intact. During an observation on 11/27/2023 at 10:00AM, in the resident's room, showed a bottle of Flonase nasal spray on the resident's overbed table within the resident's reach. During an observation on 11/27/2023 at 3:00PM, in the resident's room, showed a bottle of Flonase nasal spray on the resident's overbed table within the resident's reach. During an interview on 11/27/2023 at 3:30PM, Registered Nurse (RN) #1 stated she had administered Flonase to Resident #3 this morning and .I must have left it in the room . RN #1 stated the resident had not been assessed to self-administer medications. RN #1 confirmed medication was left within Resident #3's reach. During an interview on 11/29/2023 at 1:15PM, the Director of Nursing (DON) confirmed Resident #3 had not been assessed for self-administration of medications and the Flonase should have not been left within the resident's reach.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40640 Based on facility policy review, medical record review, and interview, the facility failed to ensure 1 resident (Resident #11) received dental services of 24 residents reviewed. The findings include: Review of the facility policy titled, Dental Services, undated, showed .The center will refer patients .for dental services within three days . Resident #11 was admitted to the facility on [DATE] with diagnoses including Acute Kidney Failure, Congestive Heart Failure, and Diabetes Mellitus. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact, and had no pain with chewing. Review of a Dental Note dated 7/6/2023, showed .teeth #7, 9 and 20 are broken to gum line .Pt [Patient] referred out to oral surgeon due to root tips needing surgical repaired . Review of the care plan dated 10/4/2023 revealed .risk of altered nutrition status .Dental services as warranted . Review of the annual MDS assessment dated [DATE], showed Resident #11 had a BIMS score of 11, which indicated the resident had moderate cognitive impariment, had no pain with chewing, and no weight loss. During an observation and interview with Resident #11 on 11/27/2023 at 9:38 AM, showed multiple upper teeth were broken and missing. Resident #11 stated she had been seen by the dentist a few months ago but had not gone back to have her broken teeth removed, and denied mouth pain. Review of the medication administration record (MAR) dated 11/1/2023-11/28/2023, showed no presence of mouth/dental pain. During an interview on 11/29/2023 at 9:05 AM, the Social Services Director confirmed the facility failed to schedule a follow up appointment with an oral surgeon for Resident #11. During an interview on 11/29/2023 at 9:53 AM, the Director of Nursing (DON) confirmed Resident #11 had not received a follow-up appointment with the oral surgeon after a referral had been made on 7/6/2023, by the dentist.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100 Based on facility policy review, observations, and interviews, the facility failed to ensure food items were sealed properly, failed to ensure kitchen cooking/ serving equipment was maintained in a sanitary manner, and failed to ensure expired foods were discarded, which had the potential to affect 96 of 96 residents. The findings include: Review of the facility's policy titled, Safe Food Storage, dated ,d+[DATE], showed .properly store food items in a safe manner .Discard food items that have passed the expiration date .Securely wrap or cover all food items . Review of the facility's policy titled, Machine Warewashing, dated ,d+[DATE], showed .Check each rack for soiled items as it comes out of the machine. Run dirty items through again until they are clean . Observation of the preparation room with the Dietary Manager (DM) on [DATE] at 9:15 AM, showed the following items was not sealed and open to air: One 21-ounce (oz) container of Garlic Powder Seasoning One 21-oz container of Nutmeg Seasoning One 21-oz container of [NAME] Pepper Seasoning One 19-oz container of Paprika One 5-pound container of Seasoning Salt Observation of the dry storage room with the DM on [DATE] at 9:20 AM, showed the following items: Two 12-quart storage containers of dry cereal, ,d+[DATE] full, was not sealed and open to air Two 106-oz cans of Sauerkraut had expired on [DATE] Observation of the clean dish storage area with the DM on [DATE] at 9:25 AM, showed the following: One divided, serving plate with dried, yellow food debris One 4-inch hotel pan with dried, yellowish-brown food debris (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on [DATE] at 9:30 AM, the DM stated dry cereals and dried seasoning are to be fully sealed in the storage containers, plates/pans are to be free of food debris after sanitization, and expired food should be discarded. The DM confirmed the food items had not been stored properly, expired food had not been discarded, and pans/plates had not been maintained in a sanitary condition.