STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445280	A. Building B. Wing	09/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Countryside Post-Acute and Rehabilitation Center	3051 Buffalo Road Lawrenceburg, TN 38464

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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** 30974 Based on policy review, observation, and interview, the facility failed to promote and enhance the resident's dignity during a dressing change for 1 of 3 sampled residents (Resident #338) reviewed. The findings include: Review of the facility's policy titled Quality of Life- Dignity, revised 2/2020, revealed .Staff promote, maintain, and protect resident privacy, including bodily during assistance with personal care and during treatment procedures . Review of the medical record, revealed Resident #338 had diagnoses of Paraplegia, Diabetes, Morbid Obesity, Congestive Heart Failure, Neurogenic Bladder, Pressure Ulcers Sacral Region and Right Ankle. Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #338 was cognitively intact and required total dependence with all activities of daily living. Wound care observation in the resident's room on 9/9/2021 at 3:08 PM, revealed the Treatment Nurse and Licensed Practical Nurse (LPN) #1 left Resident #338 exposed on the bed during pressure injury treatment and when leaving the room, left the door open. The resident was turned on his side with his posterior exposed. During an interview on 9/9/2021 at 7:05 PM, the Treatment Nurse was asked if the resident should have been covered up during pressure injury treatment and before leaving the room, with the door left open. The Treatment Nurse stated, .I didn't even realize he was not covered. He should have been .

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 39436 Based on medical record review and interview, the facility failed to initiate a significant change Minimum Data Set (MDS) assessment within 14 days after hospice services were ordered for 1 of 21 sampled residents (Resident #12) reviewed. The findings include: Review of the medical record, revealed resident #12 had diagnoses of Parkinson's Disease, Alzheimer's Disease, Dysphagia, History of COVID-19, Bipolar Disorder, Psychotic Disorder, Dementia, and Cardiac Pacemaker. Review of a Physician Order dated 4/12/2021, revealed .Hospice to evaluate and treat . Review of a medical record, revealed there was no significant change MDS assessment completed after Resident #12's admission to hospice services. Interview on 9/9/2021 at 3:20 PM, the MDS Coordinator was asked if a significant change should have been completed when Resident #12 was ordered hospice services. The MDS Coordinator stated, .I didn't do it .

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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** 33487 Based on medical record review and interview, the facility failed to implement neurological (neuro) checks and appropriate interventions after unwitnessed falls for 2 of 2 sampled residents (Resident #85 and #86) reviewed for falls. The findings include: Review of the medical record, revealed Resident #85 had diagnoses of Cerebral Infarction, Dysphagia, Aphasia, Malignant Neoplasm of Lung, History of Covid-19, Depression, Anxiety, Failure to Thrive, and Repeated Falls. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #85 had severe cognitive deficits, required limited to extensive assistance with most of his activities of daily living, had functional limitations in range of motion with impairment on one side in both his upper and lower extremities, and had 1 fall with no injury and 1 fall with injury. Review of an Incident Investigation Note dated 8/17/2021, revealed .Resident found in floor sitting on his bottom in from [front] of the restroom door. Resident states I was going to the bathroom Resident denies any pain or injury. Resident states It hurt my pride .Resident assessed for injury and assisted back to bed. No injury noted. Patient immediately reoriented and reeducated to room, bathroom, and proper use of call light. Encouraged to request assistance from staff before getting out of bed . During an interview on 9/10/2021 at 8:34 AM, the Director of Nursing (DON) and the Regional Consultant confirmed the interventions were inappropriate for a resident with severe cognitive deficits. Review of an Alert Note dated 8/18/2021, revealed .patient was found in the floor at 1:10 pm [PM] this afternoon lying on his back at the foot of the bed .noted and inch long laceration this nurse cleaned wound and applied dressing to stop the bleeding, contacted md [medical doctor] and received the order to send out to ER [emergency room] . Review of the medical record, revealed Resident #85 returned from the emergency roiagnom on [DATE], and neuro checks were not performed for 72 hours after Resident #85's fall. During an interview on 9/10/2021 at 8:34 AM, the Director of Nursing (DON) stated, .unwitnessed falls require 72 hour neuro checks . Review of a medical record, revealed Resident #86 had diagnoses of Dementia with Behaviors, Dysphagia, Psychotic Disorder, Mood Disorder, Radiculopathy, Hypertension, and Left Foot Drop. Review of an admission MDS assessment dated [DATE], revealed Resident #86 had severe cognitive deficits, required limited to supervisory assistance with her activities of daily living, and had no functional limitations in range of motion. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Nursing Note dated 5/20/2021, revealed .Found resident sitting on floor near her bed, Resident stated that she did not know how she got on the floor but she needs help to get up. Neuro checks completed and assisted resident to her bed. Obtained vital signs and head to toe assessment completed. Resident has a hematoma to the right side of her head behind and above her ear. A SkinTear to right elbow which was cleaned with wound cleanser and steristrips applied and covered with border gauze . Review of the medical record, revealed no neuro checks were not performed for 72 hours after Resident #86's fall. Review of an Incident Investigation dated 5/24/2021, revealed .Was alerted to resident in floor beside the bed. Was readmitted today from hospital. Resident is alert with confusion .Resident was put back in bed by charge nurse and PT [Physical Therapy]. Head to toe assessment completed. Bed/Chair alarm . Review of the medical record, revealed no neuro checks were not performed for 72 hours after Resident #86's fall. Review of a Nursing Note dated 5/25/2021, revealed .Called to resident's room by her roommate. Resident sitting on the floor facing her bed. Resident stated that she did not know how she got in the floor but she needed help to get up. Head to toe assessment completed and resident assisted by 2 staff members to get up and onto the bed. Vital signs obtained . Review of the medical record, revealed no neuro checks were not performed for 72 hours after Resident #86's fall. Review of a Nursing Note dated 5/27/2021, revealed .Resident found on her stomach by the door of her room after getting out of her bed. Small 1cm [centimeter] skintear found on her left elbow which was cleaned with wound cleanser and cover with border dressing. Resident stated she fell on her bottom and voiced no complaint of pain. Neuro check WNL [within normal limits] for resident . Review of the medical record, revealed no neuro checks were not performed for 72 hours after Resident #86's fall. Review of an Incident Note dated 6/12/2021, revealed .Resident found on left side of bed with her upper torso still on bed and her knees on floor at 11:15pm. This resident BIMS [Brief Interview for Mental Status] is (99). She was assessed and assisted back to bed. Found pink quarter size round areas to front of bil [bilateral] knees. No treatment needed. Neuro initiated. Resident placed in low bed with bed alarm . Review of the medical record, revealed no neuro checks were not performed for 72 hours after Resident #86's fall. During an interview on 9/10/2021 at 10:21 AM, the DON was asked what she expects her staff to do when a resident falls. The DON stated, .I expect the nurse to be notified, the nurse to assess the resident, call the MD, family, and the DON, begin neuro checks, and complete and incident report . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/2021 at 11:30 AM, the Administrator and the Regional Consultant confirmed they did not have documentation that the neuro checks were performed for the month of May.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974 Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to maintain an indwelling urinary catheter for 1 of 2 sampled residents (Resident #338) reviewed for an indwelling urinary catheter. The findings include: Review of the facility's policy titled Foley Catheter Insertion, Male Resident, revised 10/2010, revealed .Verify that there is a physician's order for this procedure . Review of the medical record, revealed Resident #338 had diagnoses of Paraplegia, Diabetes, Morbid Obesity, Congestive Heart Failure, Neurogenic Bladder, Pressure Ulcers Sacral Region and Right Ankle. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #338 was cognitively intact, required total dependence for all activities of daily living, and had an indwelling urinary catheter. Review of the Physician Orders dated 8/31/2021, revealed .Foley output two times a day . There was no order for an indwelling urinary catheter. Observation in the resident's room on 9/7/2021 at 10:21 AM, 9/7/2021 at 12:34 PM, 9/7/2021 at 5:25 PM, 9/8/2021 at 9:35 AM, and on 9/8/2021 at 3:51 PM, revealed Resident #338 did have an indwelling urinary catheter. During an interview on 9/10/2021 at 1:55 PM, the Regional Consultant confirmed there was no physician order for the indwelling urinary catheter.

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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** 30974 Based on the policy review, medical record review, observation, and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status, and failed to accurately assess, implement, and monitor interventions to prevent severe weight loss for 1 of 4 sampled residents (Resident #22) for weight loss. The findings include: Review of the facility's policy titled Weight Assessment and Intervention, revised 9/2008, revealed .nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter .weights will be measured monthly .dietitian will review the unit weight record by the 15th of the month to follow individual weight trends over time .threshold for significant unplanned and undesired weight loss will be based on the following criteria .3 months - 7.5% weight loss is significant; greater than 7.5% is severe . Review of the medical record, revealed Resident #22 was admitted to the facility on [DATE] and had diagnoses of Cerebral Infarction, Aphasia, Diabetes, and Dysphasia. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #22 had severe cognitive impairment and required total assistance with activities of daily living. Review of the undated Care Plan revealed, .Potential for weight concerns/at risk for malnutrition . Monitor/record/report to MD [medical doctor] PRN [as needed] s/sx [signs/symptoms] of malnutrition: Emaciation (Cachexia), muscle wasting, significant weight loss: 3 lbs [pounds] in 1 week, > [greater than] 5% [percent] in 1 month, >7.5% in 3 months, >10% in 6 months .RD [Registered Dietitian] to evaluate and make diet change recommendations . Review of the Physician's Orders dated 5/11/2021, revealed Registered Dietician to eval [evaluate] and treat as needed . Review of the weights revealed the following: a. 5/12/2021 228.8 lbs b. 8/5/2021 193.8 lbs (which is significant weight loss of 15.30% in 3 months) c. 9/8/2021 210.2 lbs The facility failed to follow the policy when they did not obtain resident weights on admission or weekly for two weeks after admission. During an interview on 9/9/2021 at 2:48 PM, the Nurse Practitioner stated, .We got a new dietitian a month ago .a new DON [Director of Nursing] .something was going on with the Restorative technician that did the weights .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 30974 Based on policy review, medical record review, observation, and interview, the facility failed to ensure 1 of 5 nurses (Licensed Practical Nurse (LPN) #7) followed the facility policy for medication administration through a percutaneous endoscopic gastrostomy (PEG) tube for 1 of 2 sampled residents (Resident #24) observed receiving medications through a PEG tube. The findings include: Review of the facility's policy titled Administering Medications through an Enteral Tube, revised 11/2018, revealed .Dilute medication . Dilute crushed (powdered) medication with at least 30 ml [milliliters] purified water (or prescribed amount) .pour diluted medications into the barrel of the syringe . Review of the medical record, revealed Resident #24 had diagnoses of Gastrostomy Tube, Cellulitis of Abdominal Wall, Diaphragmatic Hernia, Dysphagia, and Gastroesophageal Reflux Disease. Review of the Physician's Orders dated 7/12/2021, revealed .Flush peg tube with 100cc [cubic centimeter] of water every shift to keep tube patent . Observation in the resident's room on 9/8/2021 at 10:57 AM, revealed LPN #7 administered the dry, crushed medications to Resident #24 without diluting with water and administered each medication individually, dry into the barrel of the syringe. LPN #7 followed each medication with 5 ml of water poured into the barrel of the syringe. The last medication clogged up in the syringe. Then LPN #7 reconnected the syringe to the PEG and used the plunger to push the medication through the PEG tube. During an interview on 9/8/2021 at 6:10 PM, LPN #7 confirmed she administered medications without diluting them with water. During an interview on 9/10/2021 at 4:55 PM, the Regional Consultant confirmed that dry, crushed medications administered through a PEG tube should be diluted before administration.

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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** 33487 Based on policy review, observation, and interview, the facility failed to ensure food was stored, prepared, and served under sanitary conditions as evidenced by expired food items in the cooler, 1 of 5 Kitchen staff (Cook #1) failed to practice infection control while performing tray line temperatures, and 2 of 3 (West and East Hall) nourishment refrigerators were dirty. This had the potential to affect 75 of 85 residents who had received a tray from the Kitchen. The findings include: Review of the facility's undated policy titled, Getting Ready to Take Food Temperatures Sanitizing The Thermometer, revealed .The thermometer must be first sanitized and calibrated .The thermometer must be sanitized to avoid contaminating the food being tested .wipe the stem of the thermometer with an alcohol swab between measurements . Observation of the walk in cooler in the Kitchen on [DATE] beginning at 9:30 AM, revealed 8 of 15 quarts of Scrambled Egg Mix with an expiration date of [DATE]. Observation of the walk in cooler in the Kitchen on [DATE] at 7:50 AM, revealed a new case of 14 quarts (1 quart had been used) of Scramble Egg Mix with an expiration date of [DATE]. During an interview on [DATE] at 7:50 AM, the Certified Dietary Manager (CDM) stated, .the 8 quarts from yesterday and 1 quart from today's case was used to make scrambled eggs for the residents this morning . Those quarts were not rotated out, it was my responsibility . The CDM confirmed the expiration date of [DATE] and the expired cartons were disposed of. Observation in the Kitchen on [DATE] at 11:27 AM, revealed [NAME] #1 taking temperatures along the tray line prior to lunch. She wiped the digital thermometer off with a paper towel, placed the thermometer into a glass of ice water to calibrate, then placed the thermometer into the turkey and wrote the temperature down. She then wiped the thermometer off with the same paper towel, placed the thermometer into a glass of ice water, then placed the thermometer into the gravy and wrote the temperature down. She then wiped the thermometer off with the same paper towel she had previously used to clean the thermometer with after taking the turkey's temperature. The cook proceeded this process until the temperature of all 14 food items had been taken. During an interview on [DATE] at 11:45 AM, the CDM was asked to observe her cook and tell this writer if she saw anything wrong with the procedure her cook was using for taking the temperatures. The CDM stated, .she is using the same paper towel to wipe the thermometer off each time she removes the thermometer from a food item . The CDM then proceeded to the kitchen sink and pulled several paper towels and gave them to the cook. The CDM was asked if that was the appropriate way to disinfect the thermometer to prevent cross contamination. The CDM stated, .we've always used paper towels . The CDM was asked if she ever used alcohol wipes. The CDM stated, .we don't have any . Observation of the [NAME] Hall nourishment refrigerator on [DATE] at 2:30 AM, revealed unknown spilled substances in the drawers and on the shelves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation of the East Hall nourishment refrigerator on [DATE] at 6:45 PM, revealed unknown spilled substances in the drawers and on the shelves. Interview with the Regional Nurse on [DATE] at 6:48 PM, stated, .this sure needs to be cleaned .

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 30974 Based on medical record review and interview, the facility failed to ensure a Physician's Order was obtained related to Hospice for 1 of 1 sampled resident (Resident #21) reviewed for hospice. The findings include: Review of a medical record, revealed Resident #21 had diagnoses of Dementia with Behavioral Disturbances, History of Covid-19, Cerebral Infarction, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the medical record, revealed Resident #21 was receiving hospice but there was no Physician Order or Care Plan for hospice. During an interview on 9/10/2021 at 10:10 AM, the Regional Consultant stated, No, she [Resident #21] didn't initially have an order for Hospice.

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F 0886 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Perform COVID19 testing on residents and staff. 39436 Based on facility policy, COVID 19 testing log review, and staff interview, the facility failed to develop and implement a system to track and ensure all staff were tested for COVID-19 twice weekly for the prevention and potential spread of COVID 19 when 29 of 42 staff members (Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #2, #3, #4, #7, and #8, Certified Nursing Assistant (CNA) #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, and #14, Occupational Therapist (OT) #1 and #2, Physical Therapist Assistant (LPT) #1, Housekeeper #1, #2, and #3, Certified Dietary Manager (CDM), Receptionist #1, and [NAME] #1 and #2) failed to perform COVID 19 testing for 6 days of 18 days (8/23/2021, 8/26/2021, 8/30/2021, 9/2/2021, 9/6/2021, and 9/9/2021) reviewed. The findings include: Review of the facility's policy titled Covid Guidance . dated 4/27/2021, revealed .TESTING: Unvaccinated staff must continue to be routinely tested based on county positivity rates .> [greater than] 10% 2 x week [twice a week] . Review of the facility's COVID TESTING logs from 8/23/2021-9/9/2021 revealed the following employees failed to perform the required COVID 19 testing: a. 8/23/2021 - CNA #1, LPN#2, and LPN #3. b. 8/26/2021 - CNA #1 and LPN #2 c. 8/30/2021 - LPN #3, #4, and #5 d. 9/2/2021 - CNA #2 and LPN #4 e. 9/6/2021 - CNA #1, #2, #4, #5, #6, #7, #8, #9, #10, and #11, LPN #7 and #8, RN #1, the CDM, Housekeeper #1 and #2, OT #1 and #2, PTA #1, and [NAME] #1. f. 9/9/2021 - CNA #5, #8, #9, #10, #11, and #13, LPN #2, #3, #4, #7, and #8, Receptionist #1, [NAME] #2, and Housekeeper #3. During an interview on 9/10/2021 at 10:30 AM, the Administrator was asked about the blank spaces on the testing log and what the blank spaces meant. The Administrator stated, .That's a good question. The Administrator was asked if any staff member was making sure the staff tested prior to working. The Administrator stated, I don't know. During an interview on 9/10/2021 at 2:40 PM, the Administrator stated, .there are 48 total employees that should test on testing dates .they [staff] get busy and forget .they will be re-educated on the importance of testing . The Administrator was asked if the staff should be tested twice weekly. The Administrator stated, Absolutely.