STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445448	A. Building B. Wing	05/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Clarksville	198 Old Farmer Road Clarksville, TN 37043

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on policy review, medical record review, and interview, the facility failed to provide an accurate Baseline Care Plan for 4 of 4 sampled residents (Resident #1, #2, #3 and #4) reviewed with Baseline Care Plans. The findings include: 1. Review of the facility's policy titled, Baseline Care Plan Policy, effective date 9/23/2022, revealed . Complete a Baseline Care Plan to promote continuity of care and communication among nursing home stakeholders, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission .Baseline Care Plan will be working tool for the first 48 hours . Review of the facility's policy titled, Admission Assessment and Follow-Up Tool, last revised dated 11/6/2019, revealed .Admission Information (history and physical), including A summary of the individual's recent medical history, including hospitalization s, acute illnesses, and overall status prior to admission. Relevant medical, social, and family history. A list of active medical diagnoses and patient problems (such as recurrent falling or impaired mobility), especially those most related to reasons for admission to the facility and those that are affecting function, behavior, cognition, nutrition, hydration, quality of life, likelihood of functional recovery, and ability to participate in activities and to socialize. Current medications and treatments. Conduct a physical evaluation, including the following systems: .Eyes, Ears, Nose, Throat, Head and Neck, Teeth and Gums, Cardiovascular, Respiratory, Neurological, Musculoskeletal, Gastrointestinal, Genito-Urinary, Skin. Conduct supplemental evaluations .Skin .Reconcile the list of medications from the medication history, admitting orders, the previous medical record, Electronic Medication Administration Record [EMAR], and the discharge summary from the previous institution .Contact the Attending Physician to communicate and review the findings of the initial evaluation and any other pertinent information and obtain admission orders that are based on these findings. Notify other disciplines and departments of the resident's admission . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses Malignant Neoplasm of Major Salivary Gland, Diabetes Mellitus Type 2, Tracheostomy, Dysphagia. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Admission Observation for Information dated 1/12/2023 at 4:07 PM, revealed . Urinary Catheter yes .type of catheter indwelling .IV Central line present yes, type of IV/Central line PICC, IV dressing intact and dry yes .Nutrition Swallowing Problems none .Tube Feeding yes .Tube Feeding site Nasogastric . Review of Resident #1's Admission Note dated 1/12/2023 at 4:18 PM, revealed able to make needs known, speech unclear, ambulated to bathroom x1 assist, gait unsteady, Foley catheter in place draining clear yellow urine, nasogastric (NG) a tube inserted through the nose goes down the esophagus to the stomach) in place, intravenous (IV) Central line present yes, type of IV/Central line Peripherally Inserted Central Line ((PICC) - a tube/line inserted into a major vein that leads to the heart), IV dressing intact and dry yes. Review of Resident #1's 48-Hour Baseline Care Plan dated 1/13/2023 at 10:06 AM, revealed the following: ADL [activities daily living] functioning/Rehab within normal limits? documented, yes [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked aftercare GI/GU [gastrointestinal/genitourinary], check desired approaches revealed not checked therapy eval and treat per MD order, follow therapy recommendations once eval completed, keep call light within reach and encourage use for assistance. Bowel and Bladder elimination are within normal limits? documented, yes [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked catheter, check desired approaches revealed not checked Observe for signs and symptoms of UTI [urinary tract infection], catheter care per policy if needed. Dietary is resident at risk for unstable weight? documented, no [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked Feeding tube, Chewing or swallowing problems, check desired approaches revealed not checked Diet per MD order, Observe weight per MD order, Consult with dietician, Speech Therapy eval and treat per MD order, Tube feeding per dietician recommendations with MD order, Tube flushes per dietician recommendations with MD order. Medication Usage is resident at risk of adverse effects from necessary medications? documented, no [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked Anti-coagulants, Insulin, Diuretics, check desired approaches revealed not checked Administer meds per MD order, Observe for side effects of medication and notify MD if any noted, If injections, rotate injection sites, and observe for redness, warmth, or edema at sites. Review of Resident #1's Nursing Leader Wound Assessment Observation Information dated 1/13/2023 at 1:25 PM, revealed .IV/Central line present yes .Type of IV/Central Line Peripherally Inserted Central Catheter [PICC] .IV dressing intact and dry yes . Review of the 48 Hour Baseline Care Plan revealed no documentation of Resident #1's PICC line and care of the PICC line. 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses Cerebral Infarction with right sided Hemiplegia/paresis, Dysphagia, Aphasia, Dysarthria, Hypertension, Atrial Fibrillation and Urinary Retention. (continued on next page)

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Physician's Orders revealed the following: 5/16/2023 Aspirin tablet delayed release 81 mg (milligram) 1 tab oral once a day. 5/16/2023 Brilinta (ticagrelor) tablet 60 mg 1 tab oral twice a day. 5/16/2023 Lasix (furosemide) tablet 40 mg 1 tab oral once a day. 5/16/2023 Xarelto (rivaroxaban) tablet 20 mg 1 tab oral once a day. 5/16/2023 Repatha SureClick (evolocumab) pen injector 140 mg/ml 1 ml subcutaneous once a day on Tue Every 2 weeks. Review of Resident #2's 48-Hour Baseline Care Plan dated 5/16/2023 at 7:00 PM, revealed the following: Communication Resident's communication is understood documented, yes [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked Resident has difficulty making self-understood, Aphasia, check desired approaches revealed not checked, If necessary, ask simple yes/no questions, Allow resident adequate time to respond, Speech Therapy eval and treat as needed. Dietary is resident at risk for unstable weight? documented, no [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked Chewing or swallowing problems, Requires assistance for eating/drinking, Mechanically altered diet, check desired approaches revealed not checked Diet per MD order, Observe weight per MD order, Consult with dietician, Speech Therapy eval and treat per MD order, Observe meal and fluid intake, Provide adaptive equipment and assistance to ensure adequate meal intake. Medication Usage is resident at risk of adverse effects from necessary medications? documented, no [inaccurate], Review of Resident #2's Physician's Orders dated 5/18/2023, revealed .Dietary .Regular, Dys [dysphagia] Puree Special Instructions Porvale cups for all liquids, 1:1 supervision with meals, oral care after meals . General Patient to have 1:1 supervision with meals and provide oral care after eating . There was no documentation the Baseline Care Plan included the 5/18/2023 physician's dietary orders. 4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses End Stage Renal Disease with Dialysis, Anorexia, Congestive Heart Failure, Lupus, Functional Quadriplegia, Ileostomy, Stage 4 Sacral Pressure Ulcer, UTI (Urinary Tract Infection), Severe Sepsis, VRE (Vancomycin Resistant Enterococcus) culture positive, PICC (Peripheral Inserted Central Catheter) Infection, and Seizures. Review of Resident #3's Physician's Orders revealed the following: (continued on next page)

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/28/2023 Hydrocodone-Acetaminophen Schedule II tablet 10-325 mg 1 tab oral every 6 hours PRN (as needed) 4/28/2023 Remeron (mirtazapine) tablet 30 mg 1 tab once a day bedtime (HS). 4/28/2023 Cleanse wound to sacrum w/NS (normal saline) or wound cleanser, pat day, apply Medi honey to wound bed and cover w/foam dressing every day (QD) and as needed (PRN). 4/28/2023 Change PICC Line dressing PRN soiling or dislodgement. Review of Resident #3's Hospital Discharge Orders dated 4/28/2023, revealed .Daptomycin [Cubicin] 450 mg IV Q [every] 48 H [hours] 14 days .Fluconazole [Diflucan] 200 mg PO [by mouth] Q 24 H 10 days . Review of Resident #3's Admission Observation dated 4/28/2023 at 10:30 PM, revealed category Special Treatment and Programs while not a resident, Check all of the following treatments, programs, and procedures that were performed during the last 14 days While NOT a Resident revealed IV medications not checked, Infectious Disease Current Infections revealed no checked (inaccurate). Review of Resident #3's 48-Hour Baseline Care Plan dated 4/29/2023 at 4:10 PM, revealed the following: Skin Integrity, check desired approaches revealed not checked Pressure ulcer care, Dressings per MD order. Medication Usage is resident at risk of adverse effects from necessary medications? documented, no [inaccurate], Check history of or observed triggers and proceed to approaches revealed not checked Analgesics/Opioids, Antibiotics, check desired approaches revealed not checked Administer meds per MD order, Observe for side effects of medication and notify MD if any noted. Infectious Disease does resident have an or being treated for infectious process? documented no (inaccurate), Check history of or observed triggers and proceed to approaches revealed not checked Resident receiving IV antibiotics, check desired approaches revealed not checked Administer meds per MD order, Notify MD of adverse effects. Review of the 48 Hour Baseline Care Plan revealed no documentation of Resident #3's PICC line and care of the PICC line. 5. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses Acute Pancreatitis with Abscess, Accordion drain tube in back region to drain abscess, Necrotizing Pancreatitis, and Protein Calorie Malnutrition. Resident #4 was transferred to the hospital on 5/21/2023 due to Accordion drain tube not functioning. Review of Resident #4's Physician's orders revealed the following: 5/17/2023 Zosyn (Piperacillin-tazobactam) 3.375 gm (grams)/50 ml IV every 8 hours. 5/17/2023 Vancomycin 1.25 gm in 250 ml IV every 36 hours. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/17/2023 Oxycodone Schedule II tablet 10 mg 1 tab oral as needed for severe pain every 4 hours PRN. 5/18/2023 PICC Line dressing change every week. Review of Resident #4's 48-Hour Baseline Care Plan dated 5/17/2023 at 2:54 PM, revealed the following: Infectious Disease does resident have an or being treated for infectious process? documented no (inaccurate), Check history of or observed triggers and proceed to approaches revealed not checked Resident receiving IV antibiotics, Other Infectious process, check desired approaches revealed not checked Administer meds per MD order, obtain lab work per MD order, Notify MD of adverse effects. Review of the 48 Hour Baseline Care Plan revealed no documentation of Resident #4's PICC line and care of the PICC line. Review of Resident #4's Admission Observation dated 5/17/2023 at 2:54 PM, revealed category Skin IV/Central line Present revealed no (inaccurate), Type of IV/Central line revealed not checked Peripherally Inserted Central Catheter (PICC), IV dressing intact and Dry revealed nothing checked. Review of the 48 Hour Baseline Care Plan revealed no documentation of Resident #4's Accordion drain tube in resident's back region to drain abscess. 6. During an interview on 5/25/2023 at 1:55 PM, when the Director of Nursing (DON) was asked were the Baseline Care Plan for Residents #1, #2, #3, and #4 accurate, she stated .No, not accurate . The DON confirmed the Admission Observations for Resident #3 and #4 were inaccurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 29706 Based on policy review, medical record review, observation, and interview, the facility failed to provide an accurate and revised Comprehensive Care Plan for 4 of 4 sampled residents (Resident #1, #2, #3 and #4) reviewed with Comprehensive Care Plans. The findings include: 1. Review of the facility's policy titled Comprehensive Care Plans, effective date 4/6/2015 and revised 7/19/2018, revealed .A person-centered Comprehensive Care Plan that includes a measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. The care plan will include how the facility will assist the resident to meet their needs, goals and preferences .Person-centered care means the facility focuses on the resident as the center of control and supports each resident in making his or her own choices .Each resident's Comprehensive Care Plan is designed to .Incorporate identified problem areas; Incorporate risk factors associated with identified problems .Reflect treatment goals, timetables and objectives in measurable outcomes .Reflect currently recognized standards of practice for problem areas and conditions .The Comprehensive Care Plan will include the goals for admission and desired outcomes gathered from the resident and the resident representative .Care plan interventions are implemented after consideration of the resident's problem areas and their causes .The interventions will reflect action, treatment, or procedure to meet the objectives toward achieving the resident goals .Care plans are ongoing and revised as information about the resident and the resident's condition change. The nurse/Interdisciplinary Team is responsible for the review and updating of care plans. The care plan should reflect the current status of the resident and be updated with changes in the resident's status . Review of the facility's policy titled, Facility Care and Services, dated 5/15/2023, revealed .We provide general nursing care, based on instructions from your physician .Your health and well-being is a team approach: our staff, you, and your physician will develop a Care Plan for the care, support, and services needed [including any therapy] to help meet you identified health needs and personal goals. Your Care Plan will be reviewed periodically. If there is a significant change in your condition, your Care Plan will be updated accordingly, after consultation with you and your physician. If we cannot provide the care your physician orders, we can arrange for you to receive it from another services provider, whether at the facility or offsite through transportation . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses Malignant Neoplasm of Major Salivary Gland, Diabetes Mellitus Type 2, Tracheostomy, Dysphagia. Review of Resident #1's Admission Observation for Information dated 1/12/2023 at 4:07 PM, revealed . Urinary Catheter yes .type of catheter indwelling .IV Central line present yes, type of IV/Central line PICC, IV dressing intact and dry yes .Nutrition Swallowing Problems none .Tube Feeding yes .Tube Feeding site Nasogastric . (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's Admission Note dated 1/12/2023 at 4:18 PM, revealed able to make needs known, speech unclear, ambulated to bathroom x1 assist, gait unsteady, Foley catheter in place draining clear yellow urine, nasogastric ((NG) - a tube inserted through the nose goes down the esophagus to the stomach) tube in place, Central Peripherally Inserted Central Catheter (PICC), dressing intact and dry yes. Review of Resident #1's Care Plan created date 1/16/2023, revealed Category: Nutritional Status contained no documentation of Resident #1's NG tube and there was no documentation of the indwelling Foley catheter. The five-day Minimum Data Set (MDS) assessment dated [DATE], documented the resident scored a 15 on the Brief Interview of Mental Status, which indicated cognitively intact for daily decision making. Review of Resident #1's Physician's Orders dated 1/18/2023, revealed .MAY HAVE ICE CHIPS AT BEDSIDE AT ALL TIMES Every shift: Day, Night . There was no documentation the care plan was revised 1/18/2023 to include only by mouth intake of ice chips. Review of Resident #1's Care Plan created 1/16/2023 - 1/30/2023 revealed no documentation of a PICC line, care, and maintenance of the line. 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses Cerebral Infarction with right sided Hemiplegia/paresis, Dysphagia, Aphasia, Dysarthria, Hypertension, Atrial Fibrillation and Urinary Retention. Review of Resident #2's Physician's Orders revealed the following: 5/16/2023 Aspirin tablet delayed release 81 mg (milligram) 1 tab oral once a day. 5/16/2023 Brilinta (ticagrelor) tablet 60 mg 1 tab oral twice a day. 5/16/2023 Lasix (furosemide) tablet 40 mg 1 tab oral once a day. 5/16/2023 Xarelto (rivaroxaban) tablet 20 mg 1 tab oral once a day. 5/16/2023 Repatha SureClick (evolocumab) pen injector 140 mg/ml 1 ml subcutaneous once a day on Tue Every 2 weeks. 5/18/2023 Foley Catheter size 18 FR (French) 10 cc (cubic centimeters) balloon to straight drainage. Review of Resident #2's Physician's Orders dated 5/18/2023, revealed .Dietary .Regular, Dys [dysphagia] Puree Special Instructions Porvale cups for all liquids, 1:1 supervision with meals, oral care after meals . General Patient to have 1:1 supervision with meals and provide oral care after eating . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's Care Plan created dated 5/21/2023, revealed under the Category: Nutritional Status, there was no documentation of Dietary Regular, Dys [dysphagia] Puree Special Instructions Porvale cups for all liquids, 1:1 supervision with meals, oral care after meals. Review of Resident #2's Care Plan created date 5/21/2023 - 5/24/2023, revealed no documentation of Resident #2's Anti-coagulant therapy. 4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses End Stage Renal Disease with Dialysis, Anorexia, Congestive Heart Failure, Lupus, Functional Quadriplegia, Ileostomy, Stage 4 Sacral Pressure Ulcer, UTI (Urinary Tract Infection), Severe Sepsis, VRE (Vancomycin Resistant Enterococcus) culture positive, Peripheral Inserted Central Catheter PICC) Infection, and Seizures. Review of Resident #3's Physician's Orders revealed the following: 4/28/2023 Hydrocodone-Acetaminophen Schedule II tablet 10-325 mg 1 tab oral every 6 hours PRN (as needed) 4/28/2023 Remeron (mirtazapine) tablet 30 mg 1 tab once a day HS. 4/28/2023 Cleanse wound to sacrum w/NS (normal saline) or wound cleanser, pat day, apply Medi honey to wound bed and cover w/foam dressing QD and PRN. 4/28/2023 Change PICC Line dressing PRN soiling or dislodgement. Review of Resident #3's Hospital Orders upon discharge back to the facility dated 4/28/2023, revealed . Daptomycin [Cubicin] 450 mg IV Q [every] 48 H [hours] 14 days .Fluconazole [Diflucan] 200 mg PO [by mouth] Q 24 H 10 days . Review of Resident #3's Care Plan created 5/2/2023, revealed the following: Problem At risk for dialysis related complications. There was no documentation of dialysis location or days for dialysis. Problem Category: Skin Integrity. There was no documentation under Approach air mattress. Problem Category: Elimination. There was no documentation under Approach ileostomy and care of. Review of Resident #3's Care Plan created 5/2/2023 - 5/23/2023, revealed the following: There was no documentation of a PICC line, care, and maintenance of the line. Problem Category: Drug Regime, no clinically significant Medication issues identified, or Clinically Significant Medication issues identified There was no documentation of IV antibiotics or by mouth antibiotics. There was no documentation of Infection or Infectious Disease. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations in the resident's room on 5/24/2023 at 12:00 PM, revealed Resident #3 not in room, air mattress with bolster sides, personal items on overbed table, IV pole with empty IV bag and tubing hanging, label read Daptomycin 450 mg. Observations in the resident's room on 5/24/2023 at 3:00 PM, revealed Resident #3 sitting up in Geri chair, alert, and oriented x 3, well kempt, PICC line double lumen in right upper arm, Tesio dialysis catheter in right upper chest wall, positive demeanor, smiling, talkative. 5. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses Acute Pancreatitis with Abscess, Accordion drain tube in back region to drain abscess, Necrotizing Pancreatitis, and Protein Calorie Malnutrition. Resident #4 was transferred to the hospital on 5/21/2023 due to Accordion drain tube not functioning. Review of Resident #4's Physician's orders revealed the following: 5/17/2023 Zosyn [Piperacillin-tazobactam] 3.375 gm (grams)/50 ml IV every 8 hours. 5/17/2023 Vancomycin 1.25 gm in 250 ml IV every 36 hours. 5/17/2023 Oxycodone Schedule II tablet 10 mg 1 tab oral as needed for severe pain every 4 hours PRN. 5/18/2023 PICC Line dressing change every week. Review of Resident #4's Care Plan created 5/18/2023 - 5/21/2023, revealed no documentation of the Accordion drain tube in resident's back region to drain abscess, PICC line care of, flushing and maintenance, IV antibiotics, infection, or infectious disease. 6. During an interview on 5/24/2023 at 4:51 PM, when the DON was asked are the comprehensive care plans for Resident #1, #2, #3 and #4 accurate and patient centered, she stated, .No .not accurate .not patient specific .I see what you are saying about their care plans .that is what it looks like .

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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** 29706 Based on policy review, record review, observations and interviews, the facility failed to follow physician's orders for 3 of 4 sampled residents (Resident #1, #2 and #3) with physician's orders. The findings included: 1. Review of the facility's policy titled, Referral to Rehab dated 2/2006 revised 12/29/2022, revealed . Rehabilitation services are initiated upon a written referral to rehab from a patient's physician or member of the nursing staff and only directed by physician's order [includes telephone orders] . Review of the facility's policy titled, Review of Physicians Orders, dated 6/1/2015 and reviewed 4/14/2021, revealed .It is the standard of this facility that physician orders are reviewed daily to ensure delivery of applicable care, tracking of change of condition and updating of care plans are consistently provided. Guideline: Physician orders be reviewed daily by nursing administration during the Clinical Meeting. New orders in the Electronic Medical Record (EMR), Care Plans, Dietary, etc., will be reviewed by the interdisciplinary team to ensure updates/changes have occurred . Review of the facility's policy titled, Facility Care and Services, dated 5/15/2023, revealed .We provide general nursing care, based on instructions from your physician .Your health and well-being is a team approach: our staff, you, and your physician will develop a Care Plan for the care, support, and services needed [including any therapy] to help meet you identified health needs and personal goals. Your Care Plan will be reviewed periodically. If there is a significant change in your condition, your Care Plan will be updated accordingly, after consultation with you and your physician. If we cannot provide the care your physician orders, we can arrange for you to receive it from another services provider, whether at the facility or offsite through transportation . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], following discharge from the hospital, with diagnoses Malignant Neoplasm of Major Salivary Gland, Diabetes Mellitus Type 2, Tracheostomy, Dysphagia. Review of Resident #1's hospital DC [Discharge] Info/Summary revealed .Patient [Resident #1] continues to c/o [complain] of difficulty swallowing with ice chips and recommend further ST [speech therapy] follow up for dysphagia therapy .1/12/2023 NPO [nothing by mouth] except for ice chips for comfort. Continue TF [tube feeding] with Jevity 240 cc [cubic centimeters] AC [meals] HS [bedtime] via pump over 1 hr [hour]; flush with 120 cc of water before and after TF [tube feeding] .foley to bsb [bed side bag] . Review of Resident #1's Admission Observation for Information dated 1/12/2023 at 4:07 PM, revealed . Urinary Catheter yes .type of catheter indwelling .IV Central line present yes, type of IV/Central line PICC, IV dressing intact and dry yes .Nutrition Swallowing Problems none .Tube Feeding yes .Tube Feeding site Nasogastric . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Clarksville	198 Old Farmer Road Clarksville, TN 37043

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #1's Admission Note dated 1/12/2023 at 4:18 PM, revealed able to make needs known, speech unclear, ambulated to bathroom x1 assist, gait unsteady, Foley catheter in place draining clear yellow urine, NG [nasogastric] tube in place [a tube inserted through the nose goes down the esophagus to the stomach], Central line PICC, dressing intact and dry yes. The five-day Minimum Data Set (MDS) assessment dated [DATE] documented the resident scored a 15 on the Brief Interview of Mental Status, which indicated cognitively intact for daily decision making. Review of Resident #1's Physician's Orders dated 1/18/2023, revealed .MAY HAVE ICE CHIPS AT BEDSIDE AT ALL TIMES Every shift: Day, Night . There was no documentation Resident #1 received the ordered Speech Therapy (ST) until 1/20/2023. Resident #1 was discharged to the hospital on 1/25/2023. During an interview on 5/26/2023 at 8:49 AM, the Director of Rehabilitation was asked why Resident #1 had not received a ST eval until 8 days after admission. The Director of Rehabilitation stated, .we did not have a full time ST. We only had two part time ST and they were not available. To be honest I did not even know she [Resident #1] needed ST. I was not made aware by the facility. It wasn't until care plan with her daughter and the daughter brought up that she [Resident #1] was supposed to be getting speech therapy . 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses Cerebral Infarction with right sided Hemiplegia/paresis, Dysphagia, Aphasia, Dysarthria, Hypertension, Atrial Fibrillation and Urinary Retention. Review of Resident #2's Physician Orders dated 5/18/2023, revealed .Dietary .Regular, Dys [dysphagia] Puree Special Instructions Porvale cups for all liquids, 1:1 supervision with meals, oral care after meals . General Patient to have 1:1 supervision with meals and provide oral care after eating . Observations in the resident's room [ROOM NUMBER]/24/2023 at 12:03 PM, revealed Resident #2 sitting up in wheelchair, alert and oriented to self, aphasia, attempting to talk but mumble speech became frustrated, sighed and grimace on face, became very frustrated when tried to communicate by talking, able to point with left hand without difficulty. Observations in the resident's room on 5/24/2023 at 1:02 PM, revealed Resident #2 received a lunch meal tray from CNA #1. The tray contained a plate of puree food and a Porvale cup with liquid. Certified Nursing Assistant (CNA) #1 left the room without assisting the Resident 1:1. During an interview on 5/24/2023 at 1:25 PM, CNA #1 was asked was there anything special ordered for Resident #2 when meals were served to the resident. CNA #1 stated, .No, not that I'm aware of .I just got him I don't know of anything .we don't get report at shift change. I don't know what is going on. We have to ask the residents questions to see what is going on . CNA #1 was asked if she was aware the physician had ordered 1:1 supervision with meals and oral care after meals. CNA #1 stated, .I did not know that. Oh, my gosh .I did not stay with him at breakfast and left him at lunch .I did not know . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses Acute Pancreatitis with Abscess, Accordion drain tube in back region to drain abscess, Necrotizing Pancreatitis, and Protein Calorie Malnutrition. Resident #4 was transferred to the hospital on 5/21/2023 due to Accordion drain tube not functioning. Review of the Physician orders dated 5/17/2023 - 5/19/2023, 5/19/2023 - 5/23/2023 revealed Zosyn (Piperacillin-tazobactam) 3.375 gm/50 ml IV every 8 hours. Review of the Medication Administration Record (MAR) dated 5/19/2023 at 2:00 PM, revealed no documentation of Zosyn 2:00 PM dose administered. During an interview on 5/25/2023 at 2:23 PM, the DON confirmed no documentation of 5/19/2023 2:00 PM dose of Zosyn being administered. She stated, .Yeah, I don't know why missed dose of Zosyn .it looks like the order was discontinued but at the same time rewritten as the original order .there should not have been a missed dose the orders are exactly the same .We have some work to do .

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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** 29706 Amended 6/16/2023 Based on record review, and interview, the facility failed to have a physician's order for a urinary indwelling catheter, an assessment for removal of the urinary catheter, or demonstrate that continued catheterization was necessary for 2 of 2 sampled residents (Resident #1 and #2) with indwelling urinary catheters. The findings include: 1. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses Malignant Neoplasm of Major Salivary Gland, Diabetes Mellitus Type 2, Tracheostomy, Dysphagia. Review of Resident #1's hospital's discharge back to the facility summary dated 1/12/2023, revealed .foley to bsb [bed side bag] . Review of Resident #1's Admission Note dated 1/12/2023 at 4:18 PM, revealed able to make needs known, speech unclear, ambulated to bathroom x1 assist, gait unsteady, Foley catheter [urinary indwelling catheter] in place draining clear yellow urine, nasogastric ((NG) - a tube inserted through the nose goes down the esophagus to the stomach) tube in place, Peripherally Inserted Central Catheter (PICC) line in place, dressing intact and dry. Review of Resident #1's Admission Observation for Information dated 1/12/2023 at 4:07 PM, revealed . Urinary Catheter yes . The five-day Minimum Data Set (MDS) assessment dated [DATE], documented the resident scored a 15 on the Brief Interview of Mental Status, which indicated cognitively intact for daily decision making. Resident #1 was discharged to the hospital on 1/25/2023. Review of Resident #1's Emergency Report dated 1/26/2023 at 12:27 AM, revealed .Patient with multiple possible etiologies of SIRS [systemic inflammatory response syndrome] criteria given PICC line to left upper extremity, Foley catheter .Will replace Foley with a new Foley and obtain a UA [urinalysis] . During an interview on 5/24/2023 at 5/25/2023 at 2:23 PM, the Director of Nursing (DON) stated, .She [Resident #1] did have a Foley catheter on admission and during her stay here .We don't have an order for it. Missed that one . Record review during the survey revealed Resident #1 did not have a physician's order for the use of the urinary catheter, have a plan of care to assess for removal of the catheter as soon as possible or that the resident's clinical condition demonstrated that continued catheterization was necessary. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of Resident #2's hospital Urology consult dated 5/12/2023, revealed .Voiding attempts can be attempted as an outpatient or while he is in the skilled nursing [SN] facility . Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses Cerebral Infarction with right sided Hemiplegia/paresis, Dysphagia, Aphasia, Dysarthria, Hypertension, Atrial Fibrillation and Urinary Retention. Review of Resident #2's Physician's order dated 5/18/2023, revealed Foley Catheter size 18 French (FR) 10 cubic centimeters (cm) balloon to straight drainage. Record review during the survey revealed Resident #2 did not have a plan of care to assess for removal of the catheter as soon as possible, voiding attempts per the urology consult, or that the resident's clinical condition demonstrated that continued catheterization was necessary. During an interview on 5/25/2023 at 2:23 PM, the DON was asked what the criteria was to discontinue Resident #2's catheter. The DON stated, .we don't have criteria . The DON was asked was she aware of the hospital Urology consult dated 5/12/2023. The DON stated, .We missed that . The DON was asked if the facility had policies and procedures in place for identification and documentation of clinical indications for the use of a urinary catheter and criteria for the discontinuance of the catheter when the indication for use is no longer present. The DON stated, .No .We don't have a policy and procedure for catheter services or any criteria for indications for catheter use or when to discontinue .We use the [NAME] .how to insert, catheter care and how to remove . There was no assessment for removal of the catheter.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29706 Based on policy review, medical record review, observation, and interview the facility failed to follow professional standards of practice of Peripherally Inserted Central Catheter (PICC) Infusion therapy, medication administration, and obtain Physicians Orders for 3 of 3 sampled residents (Resident #1, #3 and #4) with a PICC line. The findings include: 1. Review of the facility's policy titled, Vascular Access Devices and Infusion Therapy Procedures Maintaining Patency of Peripheral and Central Vascular Access Devices IV [Intravascular] Flush Policy and Procedure, dated 2011, revealed .Purpose to maintain the patency of all peripheral and central vascular access devices [VADs] .Vascular access devices are flushed after each infusion to clear the infused medication from the catheter lumen. A prescriber's order is needed for all IV fluids. All vascular access devices should be flushed routinely when not in use to maintain patency. Each lumen of a multi-lumen catheter must be flushed individually. Single use flushing systems are used. Vascular access devices should never be forcefully flushed. Patency is assessed using a 10 ml [milliliter] syringe to reduce the risk of catheter damage. Flush vascular access devices with 0.9% preservative free sodium chloride [normal saline] .To succeed with saline flushing, a needleless connector with an anti-reflux design must be placed on the hub of EVERY lumen of EVERY vascular access device/catheter. All connections [IV tubing or syringes] will be made via the needleless connector, NEVER directly to the catheter hub .Procedure Obtain prescriber order for appropriate flush solutions. Refer to the Flush Chart .The flush orders must be written as a complete medication order .Dispose waste per OSHA, CDC, and facility policy. Document the flush in the patient's medication record . Review of the facility's policy titled, Vascular Access Devices and Infusion Therapy Procedures Flush Chart, dated 2011, revealed .Type of IV Device Midline, PICC [Peripherally Inserted Central Catheter] Pre-Use 10 ml Saline Post-Use 10 ml Saline Minimum Intervals for flushing each lumen [whenever lumen is locked with no infusion currently running] 10 ml Saline every 8 hours = PRN [as needed] . Review of the facility's policy titled, Vascular Access Devices and Infusion Therapy Procedures Dressing Change for Vascular Access Devices, dated 2011, revealed .Purpose to prevent local and systemic infection related to the IV catheter .Central venous access device and midline dressing changes will be done at established intervals and immediately if the integrity of the dressing is compromised, if moisture, drainage or blood is present, or for further assessment if infection is suspected. Transparent semi-permeable membrane dressings are changed every 7 days and PRN. If a chlorhexidine impregnated gauze sponge [Biopatch trademark sign] is applied under the transparent dressing, change every 7 days. If a patient is allergic to the transparent dressing and a gauze and tape dressing is used over the site, the gauze dressing must be changed every 48 hours and PRN. Gauze underneath a transparent semi-permeable membrane dressing is considered a gauze dressing .If using a catheter securement device [StatLock trademark] it must be changed with each dressing change . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Review of Physicians Orders, dated 6/1/2015 and reviewed 4/14/2021, revealed .It is the standard of this facility that physician orders are reviewed daily to ensure delivery of applicable care, tracking of change of condition and updating of care plans are consistently provided. Guideline: Physician orders be reviewed daily by nursing administration during the Clinical Meeting. New orders in the Electronic Medical Record (EMR), Care Plans, Dietary, etc., will be reviewed by the interdisciplinary team to ensure updates/changes have occurred . Review of the facility's policy titled, Facility Care and Services, dated 5/15/2023, revealed .We provide general nursing care, based on instructions from your physician .Your health and well-being is a team approach: our staff, you, and your physician will develop a Care Plan for the care, support, and services needed [including any therapy] to help meet you identified health needs and personal goals. Your Care Plan will be reviewed periodically. If there is a significant change in your condition, your Care Plan will be updated accordingly, after consultation with you and your physician. If we cannot provide the care your physician orders, we can arrange for you to receive it from another services provider, whether at the facility or offsite through transportation . Review of the facility's policy titled, Medication Administration, dated 2007, revealed .Medications are administered in accordance with written orders of the prescriber . 2. Review of the medical record, revealed Resident #1 was admitted to the facility on [DATE], with diagnoses Malignant Neoplasm of Major Salivary Gland, Diabetes Mellitus Type 2, Tracheostomy, Dysphagia. Review of Resident #1's Admission Note dated 1/12/2023 at 4:18 PM, revealed able to make needs known, speech unclear, ambulated to bathroom x1 assist, gait unsteady, Foley catheter in place draining clear yellow urine, NG [nasogastric] tube in place [a tube inserted through the nose goes down the esophagus to the stomach], PICC line in place, and the PICC line dressing was intact and dry. Review of Resident #1's Nursing Leader Wound Assessment Observation Information dated 1/13/2023 at 1:25 PM, revealed .Central line present yes .Central Line Peripherally Inserted Central Catheter [PICC] .IV dressing intact and dry yes . Review of the Physician's Orders dated 1/12/2023, revealed no documentation of an order for a PICC, maintenance of the PICC line with normal saline flushes or dressing change. Review of Resident #1's nurse's notes date ranges 1/14/2023 - 1/25/2023 revealed no documentation of resident having a PICC line or being provided care for maintenance of a PICC line as per facility policy. The five-day Minimum Data Set (MDS) assessment dated [DATE] documented the resident scored a 15 on the Brief Interview of Mental Status, which indicated cognitively intact for daily decision making. Resident #1 was discharged to the hospital on 1/25/2023. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #1's emergency room (ER) Report dated 1/26/2023 at 12:27 AM, revealed .Patient with multiple possible etiologies of SIRS [systemic inflammatory response syndrome] criteria given PICC line to left upper extremity, Foley catheter, skin changes to bilateral feet and NG tube with risk for aspiration pneumonia. High suspicion for aspiration pneumonia given new hypoxia and tachypenic .Will replace Foley with a new Foley and obtain a UA [urinalysis]. PICC line remains in place in the left upper extremity, however family states that this is no longer used . During an interview on 5/24/2023 at 4:51 PM, the Director of Nursing (DON) was asked was the facility aware Resident #1 came from the hospital on admission with a PICC line and did the facility provide maintenance and dressing changes for Resident #1's PICC line. The DON stated .I can't find anything about the PICC line .Evidently she came with one from the hospital based on the admission observation but there is nothing in the record after that .I don't know what happened . The DON confirmed the ER record dated 1/26/2023 at 12:27 AM documented the resident had a PICC line when she came from the facility to the ER. She stated, .Yes . When the DON was asked for clarification Resident #1 had a PICC when admitted to the facility on [DATE] and had a PICC when transferred from the facility to theER on [DATE], she stated, .yes [Resident #1] had PICC while she was here, didn't catch it .It slipped through the cracks, we missed it .I acknowledge it . 3. Review of the medical record, revealed Resident #3 was admitted to the facility on [DATE], with diagnoses End Stage Renal Disease with Dialysis, Anorexia, Congestive Heart Failure, Lupus, Functional Quadriplegia, Ileostomy, Stage 4 Sacral Pressure Ulcer, Severe Sepsis, VRE (Vancomycin Resistant Enterococcus) culture positive, PICC (Peripheral Inserted Central Catheter) Infection, and Seizures. Review of Resident #3's Hospital Discharge Orders dated 4/28/2023, revealed .Daptomycin [Cubicin] 450 mg IV [intravenous] Q [every] 48 H [hours] 14 days .Fluconazole [Diflucan] 200 mg PO [by mouth] Q 24 H 10 days . Review of the facility's Physician's orders dated 4/28/2023 - 5/12/2023, revealed no orders for Daptomycin 350 mg (milligrams) IV daily every other day and no order for Normal Saline (sodium chloride 0.9% 10 ml every shift flush before and after medication administered. Physician's orders also revealed no order for PICC maintenance Normal Saline flush as per facility policy. Review of the Medication Administration Record (MAR) dated 5/10/2023, revealed last normal saline flush dated was 5/10/2023 after antibiotic infusion. Review of the MAR dated 5/12/2023, revealed no documentation of Normal Saline IV flush administered before or after 5/12/2023 medication administration. Review of the MAR dated 5/12/2023 - 5/24/2023, revealed no documentation of PICC maintenance flush of Normal Saline as per facility policy. During an interview on 5/24/2023 at 3:00 PM, when asked about the empty IV bag hanging on the IV pole, the DON stated .yeah that was my antibiotic .I finished that days ago .I don't know why it is still hanging there . When asked did the staff flush the PICC line before medication administration and after, she stated .yes . When asked had the staff flushed the PICC line since the last medication dose, the DON stated .no . (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations in the resident's room on 5/24/2023 at 12:00 PM, revealed Resident #3 was not in the room. In the room were an air mattress with bolster sides, personal items on overbed table, IV pole with empty IV bag and tubing hanging, label read Daptomycin 450 mg. Observations in the resident's room on 5/24/2023 at 3:00 PM, revealed Resident #3 sitting up in Geri chair, alert, and oriented x 3, well kempt, PICC line double lumen in right upper arm, Tesio dialysis catheter in right upper chest wall, positive demeanor, smiling, talkative. During an interview on 5/25/2023 at 2:23 PM, the DON confirmed there was no documentation the IV/PICC line had been flushed before or after Daptomycin administered 5/12/2023. The DON stated, .That's what it looks like .I see exactly what you are seeing . When asked is there an order to flush the PICC for maintenance as per facility policy, the DON stated, .I don't see any order or documentation about a maintenance flush .I see what our policy says . When asked does the facility have a policy for when to change the needleless connector that goes on the hub of the PICC lumen, the DON stated, .we don't have a policy on when to do that . When asked does your facility know the standard of practice of to change the needleless connector on each lumen of the Central Vascular Access Device every seven days, the DON stated, .No, we have no policy . 4. Review of the medical record, revealed Resident #4 was admitted to the facility on [DATE], with diagnoses Acute Pancreatitis with Abscess, Accordion drain tube in back region to drain abscess, Necrotizing Pancreatitis, and Protein Calorie Malnutrition. Resident #4 was transferred to the hospital on 5/21/2023 due to Accordion drain tube not functioning. Review of the Physician's orders dated 5/17/2023 - 5/19/2023, revealed Zosyn [Piperacillin-tazobactam] 3. 375 gm/50 ml IV every 8 hours. Vancomycin 1.25 gm in 250 ml IV every 36 hours. Review of the Physician's orders dated 5/17/2023 - 5/19/2023, revealed no orders to flush PICC with Normal Saline before and after IV medication administration. Review of the MAR dated 5/17/2023, revealed no documentation of a Normal Saline flush administered to PICC line before or after administration of Zosyn dose at 10:00 PM. Review of the MAR dated 5/18/2023, revealed no documentation of a Normal Saline flush administered through the PICC line before or after administration of Zosyn doses at 6:00 AM, 2:00 PM, 10:00 PM. Review of the MAR dated 5/18/2023, revealed no documentation of a Normal Saline flush administered through the PICC line before or after administration of Vancomycin dose at 4:00 PM. Review of the MAR dated 5/19/2023 at 2:00 PM, revealed no documentation of Zosyn 2:00 PM dose administered. Review of the MAR dated 5/18/2023 - 5/23/2023, revealed flush PICC twice a day flush before and after medication administration. Observations in Resident #4's room [ROOM NUMBER] B on 5/24/2023 at 11:00 AM, revealed bed made, IV pole with empty IV bag infused medication labeled Zosyn Piperac-tazo 3.375 gm (grams)/50 ml infuse every 8 hours. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/24/2023 at 11:12 AM, when the DON was asked about the IV pole with the empty IV bag labeled with antibiotic still hanging on the IV pole in the Resident's room, the DON stated .She [Resident #4] has been gone since Sunday [5/21/2023] .they should have disposed of that IV bag days ago . During an interview on 5/25/2023 at 2:23 PM, the DON confirmed no documentation of physician's order for Normal Saline flush before and after antibiotic administration through PICC line and missed 2:00 PM dose of Zosyn on 5/19/2023. She stated, .Yeah, I don't know why missed the Zosyn .it looks like the order was discontinued but at the same time rewritten as the original order .there should not have been a missed dose the orders are exactly the same .I don't know why there is no flush order on the physician's orders but it is written on the MAR .there should have been an order to flush for each antibiotic .antibiotic administered different times .We have some work to do .