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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445013	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER: Nhc Healthcare, Chattanooga		STREET ADDRESS, CITY, STATE, ZIP CODE: 2700 Parkwood Ave Chattanooga, TN 37404	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Resident #84 was admitted to the facility on [DATE], with diagnoses including Non-Alzheimer's Dementia, Anxiety, Depression and Psychotic Disorder. Review of Resident #84's PASRR submission dated 9/5/2024, revealed the resident was considered by the state designated agency to have a level 2 outcome. Review of Resident #84's admission MDS assessment dated [DATE], revealed the resident was not coded as a resident currently considered by the state to have a level 2 outcome. During an interview on 10/17/2024 at 5:50 PM, the MDS Supervisor stated Resident #35, Resident #81 and Resident #84 were currently determined by the state designated agency to have a level 2 outcome and confirmed Resident #35, Resident #81 and Resident #84 were not accurately coded for a PASRR level 2 on the MDS assessment. Based on facility policy review, medical record review and interview, the facility failed to accurately code a Preadmission Screening and Resident Review (PASRR) level 2 on the Minimum Data Set (MDS) assessment for 3 residents (Resident #35, Resident #81 and Resident #84) of 7 residents reviewed for PASRR. The findings include: Review of the facility's policy titled, Pre-admission SCREENING & [and] Resident Review (PASRR), revised 11/2016, revealed .requires all centers to screen patients .to determine if they have Mental Illness, Intellectual or Developmental Disability .those patients found nursing facility appropriate under Level II [2] review, the Center [facility], should incorporate .PASRR Level II determination .into the patient's assessments (MDS) . Resident #35 was admitted to the facility on [DATE], with diagnoses including Parkinson's Disease, Failure to Thrive, Bipolar Disorder, Hallucinations and Insomnia. Review of Resident #35's PASRR submission dated 6/27/2023, revealed the resident was considered by the state designated agency to have a level 2 outcome. Review of Resident #35's significant change MDS assessment dated [DATE], revealed the resident was not coded as a resident currently considered by the state to have a level 2 outcome. (continued on next page)

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

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #81 was admitted to the facility on [DATE], with diagnoses including, Bipolar Disorder, Anxiety, Emotional Liability and Nicotine Dependence. Review of Resident #81's PASRR submission dated 7/19/2024, revealed the resident was considered by the state designated agency to have a level 2 outcome. Review of Resident #81's significant change MDS assessment dated [DATE], revealed the resident was not coded as a resident currently considered by the state to have a level 2 outcome.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on facility policy review, medical record review and interview, the facility failed to implement a person centered comprehensive care plan intervention related to falls for 1 resident (Resident #51) of 3 residents reviewed for falls. The findings include: Review of the facility's policy titled, Documentation Guidelines, revised 6/2023, revealed .Care Plan Approaches [interventions] are specific, individualized steps partners [staff] and patients will take together to assist the patient to achieve the goal .Approaches serve as instructions for patient care . Review of the facility's undated policy titled, [Named facility] FALLS PROGRAM, revealed .to reduce the patients' risk of falling .implement appropriate interventions .Evaluate effectiveness of the interventions . Review of the facility's undated policy titled, L.A.M.P (Look at me please), revealed .L.A.M.P is a program initiated within the facility .means of communication to alert the staff of the individual's specific fall intervention needed . Medical record review revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Low Blood Pressure While Standing, Bradycardia, History of Falls, Dementia and Osteoporosis. Review of the facility's document for Resident #51 titled, POST FALL INVESTIGATION, dated 9/12/2024, revealed the resident had a witnessed fall while ambulating in the hallway on 9/12/2024, and the L.A.M.P program was listed as the facility's post fall intervention. Review of the significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #51 was unable to complete the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review of the Significant Change MDS revealed the resident had falls at the facility since admission. Review of a comprehensive care plan for Resident #51 revised 10/13/2024, revealed .At risk for falls . Approach .pt [patient] to be a participant on the L.A.M.P. program . During an observation on 10/14/2024 at 2:00 PM, Resident #51 was in her room, sitting in her wheelchair. No signage was posted on the doorway, or in the resident's room related to falls or the L.A.M.P program. During an observation on 10/17/2024, at 9:00 AM, Resident #51 was not in the room, and no signage was posted on the doorway, or in the resident's room related to falls or the L.A.M.P. program. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024, at 9:20 AM, LPN F stated .The L.A.M.P program is a picture of a lamp or sign on the resident's door frame intended to remind staff prior to entering the resident's room. The Lamp stands for look at me please and reminds staff to pay special close attention to the resident regarding falls while in the room. The sign is kept on the doorframe and not in the room and not in the closet . During an interview on 10/17/2024, at 9:30 AM, CNA G stated .The L.A.M.P program is picture that goes only on the resident's door or door frame to let us know to pay close attention to them for falls risk and there is a number written on the picture to tell you which resident is on the L.A.M.P program . During an observation and interview on 10/17/2024, at 9:35 AM, LPN F and CNA G observed the door and door frame for Resident #51's room and confirmed there was no L.A.M.P signage in use for the resident. During an interview on 10/17/2024, at 10:00 AM, the Care Plan Coordinator H stated the L.A.M.P program signage was to be placed on the resident's door or the resident's door frame and confirmed the L.A.M.P. program fall intervention was not implemented.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on review of facility job descriptions, medical record review, observation and interview, the facility failed to ensure 1 coffee cup was clean prior to resident use of 5 coffee cups observed. The findings include: Review of the facility job description titled, Dishwasher, revised 11/2020, revealed duties and responsibilities included, .Assists in maintaining the FNS [Food Nutrition Services] department in a .sanitary manner . Responsible for scraping .washing, and sanitizing dishes .utensils .Assembles meal trays on tray line and checks trays for .quality . Review of the facility job description titled, Food and Nutrition Services (FNS) Aide, revised 11/2020, revealed duties and responsibilities included .Assists in maintaining the FNS department in a .sanitary manner .Responsible for scraping .washing, and sanitizing dishes .utensils .Assembles meal trays on tray line and checks trays for .quality . Review of the medical record revealed Resident #94 was admitted to the facility on [DATE], with diagnoses including Mild Dementia with Anxiety, Delusional Disorders and Chronic Obstructive Pulmonary Disease. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #94 scored 13 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. The resident did not require assistance with eating. During observation and interview on 10/15/2024, at 8:52 AM, Resident #94 requested this surveyor look at the rim of her coffee cup. Observation revealed a dark substance on the rim of the coffee cup. The dark substance was easily removed when the resident wiped a small area with a tissue. The substance on the tissue was wine colored. In reference to a clock face, the handle of the coffee cup was sitting on the over bed table with the handle at 3 o'clock and the dark substance was at 12 o'clock. Resident #94 was not wearing lipstick at the time of the observation. During observation and interview on 10/15/2024, at 9:05 AM, the Director of Nursing confirmed the rim of the resident's coffee cup had a dark substance and confirmed the cup had not been properly cleaned prior to resident use. During an interview on 10/15/2024, at 11:30 AM, the Administrator stated dietary staff were expected to inspect dishes, cups, and eating utensils for cleanliness prior to serving food and drinks to residents.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review and interviews, the facility failed to ensure the medical record was accurate and complete for 1 resident (Resident #117) of 5 residents reviewed for blood glucose monitoring. The findings include: Review of the facility's policy titled, Introduction to Documentation for Inpatient Medical Records, dated 11/2023, revealed .It is the responsibility of each health care center to .maintain comprehensive records . accurately .Professional Standards of Documentation .evaluations, treatments .responses are accurately recorded .Information is recorded as near to the time of the occurrence . Resident #117 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Long term use of Insulin, Hyperglycemia and Adult Failure to Thrive. Review of the Part A PPS (Prospective Payment System) Discharge Item Set Minimum Data Set (MDS) assessment for Resident #117 dated 9/30/2024, revealed the resident had received insulin in the 7 day look back review. Review of the comprehensive care plan for Resident #117 dated 8/24/2024, revealed .Type II Diabetes . Perform fingersticks as ordered . Review of a Physician Order for Resident #117 dated 8/24/2024, revealed the order for blood sugar checks before meals and at bedtime (07:30 AM, 11:00 AM, 04:30 PM, 09:00 PM). Review of a Physician Order for Resident #117 dated 9/18/2024, revealed .Hyperglycemic Protocol .Any blood sugar 401 or greater, administer insulin per sliding scale and recheck in 2 hours. If still 401 or higher, notify medical staff for further orders . Further review of the medical record revealed Resident #117 had orders for long acting insulin (started 8/26/2024) and sliding scale insulin orders were added 10/11/2024. Review of the Medication Administration Record (MAR) for Resident #117 dated 9/1/2024-9/30/2024, revealed a blood sugar check was performed on 9/23/2024 at 4:30 PM with results of 434 mg/dl (milligram/deciliter-unit of measure). Continued review of the MAR revealed the Hyperglycemic Protocol dated 9/23/2024 had been omitted for the entire day. A repeat blood sugar should have performed 2 hours after the initial elevated blood sugar. Review of the Vitals Report for Resident #117 dated 9/23/2024, revealed the resident had a blood sugar recorded at 5:09 PM which resulted 434 mg/dl and the next blood sugar recorded at 8:01 PM which resulted 264 mg/dl (3 hours and 8 minutes later). During an interview on 10/17/2024 at 1:57 PM, Nurse Practitioner (NP) D was hesitant to increase Resident #117's insulin or order sliding scale insulin. Resident #117 was a new admission, and she was not familiar with the resident and sensitivity of his blood sugars to insulin. The NP was aware outside food was brought in by family for the resident and the resident snacked frequently. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/17/2024 at 2:24 PM, Medical Doctor (MD) E reviewed Resident #117's blood sugars for 9/23/2024 and had no issues with the single elevated blood sugar; the next blood sugar was not elevated and had come down. Resident #117 did not have to be sent to the hospital for the elevated blood sugar and had no negative outcomes. During interviews on 10/17/2024 at 4:34 PM, the Assistant Director of Nursing and the Director of Nursing confirmed Resident #117's medical record dated 9/23/2024, was incomplete and not accurate.