STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445183	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallatin Center for Rehabilitation and Healing	438 North Water Ave Gallatin, TN 37066

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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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, financial document review, medical record review, and interview, the facility failed in their fiduciary responsibility in holding, safeguarding, managing, and accounting for the deposited personal funds for 13 of 80 (Resident #3, #5, #15, #48, #51, #58, #75, #80, #84, #92, #97, #116, and #119) sampled residents. The findings: 1. Review of the facility policy titled, Management of Residents' Personal Funds, dated 2001, revealed . Should the facility manage the resident's funds, the facility will act as a fiduciary of the resident funds and hold, safeguard, manage, and account for the personal funds of the resident .funds will be managed in accordance with local, state, federal regulations . 2. Review of medical record revealed Resident #3 was admitted on [DATE], with diagnoses including Diabetes, Hypertension, and Bipolar. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #3's balance was $6067.87 which was $3167.87 over the $2900.00 limit. 3. Review of medical record revealed Resident #5 was admitted on [DATE], with diagnoses including Diabetes, Cognitive Communication Deficit, and Rheumatoid Arthritis. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #5's balance was $11,053.23 which was $8153.23 over the $2900.00 limit. 4. Review of medical record revealed Resident #15 was admitted on [DATE], with diagnoses including Dementia, Diabetes, and Schizophrenia. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #15's balance was $8380.37 which was $5480.37 over the $2900.00 limit. 5. Review of medical record revealed Resident #48 was admitted on [DATE], with diagnoses including Dementia, Kidney Disease, and Hypertension. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #48's balance was $6,027.00 which was $3127.00 over the $2900.00 limit. (continued on next page)

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

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. Review of medical record revealed Resident #51 was admitted on [DATE], with diagnoses including Diabetes and Chronic Obstructive Pulmonary Disease. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #51's balance was $4531.72 which was $1631.72 over the $2900.00 limit. 7. Review of medical record revealed Resident #58 was admitted on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, and Schizoaffective disorder. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #58's balance was $7254.24 which was $4354.24 over the $2900.00 limit. 8. Review of medical record revealed Resident #75 was admitted on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Paraplegia, Diabetes, and Heart Failure. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #75's balance was $3166.38 which was $266.38 over the $2900.00 limit. 9. Review of medical record revealed Resident #80 was admitted on [DATE], with diagnoses including Dementia. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #80's balance was $13167.48 which was $10267.48 over the $2900.00 limit. 10. Review of medical record revealed Resident #84 was admitted on [DATE] with diagnoses including Alzheimer's, Dementia, and Bipolar. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #84's balance was $4537.48 which was $1637.48 over the $2900.00 limit. 11. Review of medical record revealed Resident #92 was admitted on [DATE], with diagnoses including Dementia and Bipolar. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #92's balance was $5051.65 which was $2151.65 over the $2900.00 limit. 12. Review of medical record revealed Resident #97 was admitted on [DATE], with diagnoses including Heart Failure and Diabetes. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #97's balance was $7579.98 which was $4679.98 over the $2900.00 limit. 13. Review of medical record revealed Resident #116 was admitted on [DATE], with diagnoses including Cerebral Palsy and Paraplegia. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #116's balance was $10,416.96 which was $7516.96 over the $2900.00 limit. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	14. Review of medical record revealed Resident #119 was admitted on [DATE], with diagnoses including Heart Failure and Diabetes. Review of the Patient Trust Fund Quarterly Statement, dated 4/21/2025, revealed Resident #119's balance was $11.440.87 which was $ 8540.87 over the $2900.00 limit. 15. During an interview on 4/23/2025 at 11:36 AM, with the Regional Business Office Consultant (RBOC), the EBOC was asked when she became aware of the balance overages for the resident trust funds. The RBOC stated, I came to the facility when the previous Business Office Manager left on 2/26/2025. I became aware of it then. The RBOC was asked when she attempted to resolve the trust fund overages. The RBOC stated, This week.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, personnel file review, medical record review, facility documentation review, and interview, the facility failed to ensure the residents' rights to be free from misappropriation of property due to diversion of medications including controlled substances was maintained for 3 residents (Resident #911, #910, and #52) of 13 residents reviewed for misappropriation of resident property. The findings include: 1. Review of the facility policy titled, Residents Rights, dated 2001, revealed .Federal and state laws guarantee certain basic rights to all residents of this facility .these rights include the resident's right to .be free from abuse, neglect, misappropriation of property, and exploitation . Review of the facility policy titled, Controlled Substances, undated, revealed .The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances .The Director of Nursing [DON] Services will identify staff members who are authorized to handle controlled substances .Nursing staff must count controlled medications at the end of each shift .nurse coming on duty and the nurse going off duty must make the count together .They must document and report any discrepancies to the Director of Nursing Services .Director of Nursing/Designee Services shall investigate any discrepancies in narcotics reconciliation to determine the cause and identify any responsible parties and shall report to the Administrator .The Director of Nursing Services/Designee shall consult with the provider pharmacy and the Administrator to determine whether any further legal action in indicated . 2. Review of Registered Nurse (RN) I's personnel file revealed the RN was employed by the facility from 6/7/2023 through 6/30/2023. In 11/2023, RN I was found guilty of aggravated criminal trespassing and theft of up to $1,000.00. RN I was sentenced to 180 days of supervised probation, monetary restitution, and court costs. 3. Review of the medical record revealed Resident #911 was admitted to the facility on [DATE], with diagnoses including Encounter for Orthopedic Aftercare following Surgical Amputation, Diabetes, Chronic Pain, and Hypertension. Review of the physician orders for Resident #911 dated 6/13/2023, revealed Hydrocodone-Acetaminophen (APAP) Tablet (opioid pain-relieving medication)10-325 milligram (mg), give 1 tablet by mouth 4 times a day for Chronic Pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #911 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated Resident #911 was cognitively intact. The resident received antianxiety, antidepressant, and opioid medications. Review of the Medication Administration Record (MAR) dated 6/1/2023 through 6/30/2023, for Resident #911 revealed the resident's pain level was assessed every shift. Further review revealed Hydrocodone-APAP 10/325 mg tablet had been administered 4 times daily. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document titled, Controlled Drug Administration Record, for Resident #911 dated 6/14/2023 through 6/28/2023, revealed the following regarding the Hydrocodone-APAP 10-325mg tablet: 6/14/2023 RN I signed out the medication at 6:00 AM. RN I did not work that day. 6/15/2023 RN I signed out the medication at 6:00 AM. RN I did not work that day. 6/16/2023 RN I signed out the medication at 6:00 AM although RN FF (night shift nurse) had already signed out the medication and signed the MAR that RN FF had already administered the medication at 5:00 AM that morning (night shift nurses administer the 6:00 AM doses of medication). 6/17/2023 RN I signed out the medication at 5:00 PM X (times) 2 tablets. The documentation revealed the 1st dose appeared to have been wasted but the initials of the nurse who witnessed the wasting with RN I did not match any nurse that worked at the facility. 6/18/2023 RN I signed out the medication 6:00 AM although LPN GG (night shift nurse) had already signed out the medication on the controlled drug sheet and the MAR as being administered. RN I worked the day shift on 6/18/2024, but the night shift nurse administered the morning dose at 5:00 AM. 6/23/2024 RN I signed out 1 dose at 11:30 PM, 12:00 PM, 5:00 PM, and 6:00 PM. RN I had signed out the extra doses on separate narcotic sheets for the same medication. RN I had also signed out another dose without documenting the time. 6/24/2023 RN I signed out doses of the medication at 5:20 PM and 6:00 PM. 6/25/2023 RN I signed out the medication at 12:00 PM and 6:00 PM. RN I did not work that day. 4. Review of the medical record revealed Resident #910 was admitted to the facility on [DATE], with diagnoses including Dementia, Hypertension, and Chronic Respiratory Failure. Review of the physician orders for Resident #910 dated 1/25/2023, revealed Hydrocodone-APAP Tablet 5-325 mg, give 1 tablet by mouth at bedtime for Arthritis/Scoliosis. Review of the MAR dated 6/1/2023 - 6/30/2023 for Resident #910 revealed the resident's pain level was assessed every shift. Further review revealed Resident #910 was administered Hydrocodone-APAP 5-325 mg at bedtime per the physician's orders. Review of a quarterly MDS assessment dated [DATE], revealed Resident #910 scored a 7 on the BIMS assessment, which indicated Resident #910 had moderate cognitive impairment and received antidepressant and opioid medications. Review of the facility's document titled, Controlled Drug Administration Record, for Resident #910 dated 6/18/2023 through 6/28/2023, revealed the following related to the Hydrocodone-APAP 5-325 mg tablet: 6/19/2023 RN I signed out the medication. RN I did not work that day. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE], with diagnoses including Heart Failure, Diabetes, and Hypertension. Review of the physician orders for Resident #52 dated 6/22/2023, revealed Oxycodone-APAP 7.5-325 mg tablet (opioid pain-relieving medication) give 1 tablet by mouth every 6 hours as needed for pain. Review of the MAR dated 6/1/2023 - 6/30/2023 for Resident #52 revealed the resident's pain level was assessed every shift. Further review revealed Resident #52 was administered Oxycodone-APAP 7.5-325 mg every 6 hours as needed for pain. Review of a Medicare 5-day MDS assessment dated [DATE], revealed Resident #52 scored a 15 on the BIMS assessment, which indicated the resident was cognitively intact and received opioid medications. Review of the facility's document titled, Controlled Drug Administration Record, for Resident #52 dated 6/23/2023 - 6/28/2023, revealed the following related to the Oxycodone-APAP 7.5-325 mg tablet: 6/23/2023 RN I signed out the medication at 8:00 AM and 6:30 PM. RN I did not work that day. 6/25/2025 RN I signed out the medication at 4:00 AM, 10:00 AM, and 3:00 PM. RN I did not work that day. Review of the NP Progress note for Resident #52 dated 6/29/2023, revealed .patient seen and examined per nursing and facility request for evaluation .has been readmitted with orders for Percocet (Oxycodone-APAP) 7.5-325 mg, initially 1 tablet every 4 hours as needed which was decreased to 1 tablet every 6 hours as needed and is now decreased to every 8 hours as needed .nursing reports patient is requesting pain management approximately 1-2 times daily .does not appear to be in any acute distress .chronic pain . monitor for any increase in pain or discomfort related to decrease of medications . Review of the Progress Notes for Resident #52 dated 6/28/2023, revealed .no c/o pain/discomfort reported . Review of the Progress Notes for Resident #52 dated 6/29/2023, revealed .Social worker met with resident this afternoon. Resident was pleasant, engaged and did not voice any concerns at this time. Resident did not appear to be in any distress. Social services will continue visits and provide support as needed . Review of the Progress Notes for Resident #52 dated 6/30/2023, revealed .Social worker checked on resident this afternoon. Resident did not appear to be in any distress. Resident has been doing well today. No concerns expressed. Social services will continue visits and provide support as needed . 6. Review of the facility's document titled, Investigation Packet, for Residents #911, #910, and #52 dated 6/28/2023, revealed .ADM [administrator] spoke with .[Police department] on 6/28/2023 with Officer .ADM explained situation .concerns with narcotics and nurse [RN I] .officer indicated that he would need to speak with his supervisor for direction and stepped out of the office .officer returned and indicated there was nothing the PD could do .ADM asked officer for incident number to reflect the facility attempted to have the matter addressed by the police .gave incident number .res [resident] narcotic records were audited .residents assess by provider . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's document titled, Investigation Packet, for Residents #911, #910, and #52 dated 6/29/2023, revealed .notified the Pharmacy rep [representative] on 6/29/2023 of all .medications that would need to be replaced at the facility's expense as a result of the complete audit conducted of medication administration activity with regards to nurse [RN I] . Review of the DON's witness statement for Resident #911, #910, and #52 dated 6/29/2023, revealed .[RN I] called me to ask if she was being reported for anything .told her the investigation was underway .encourage RN I to be truthful .[RN I] stated, I took 3 pills from [Resident #911] and 2 pills from [Resident #52] .I signed them out for days I was not there . Review of the facility's document titled, Investigation Packet, for Residents #911, #910, and #52 dated 6/30/2023, revealed .ADM spoke with Officer [police officer] .on 6/30/2023 [regarding the possible drug diversion] .Explained the situation and he indicated that his department would take the information and look into possible steps and would let us know if they needed anything further from the facility to aide in a case against nurse [RN I] . During an interview on 4/21/2025 at 7:16 PM, RN I stated she worked at the facility for a short period of time in 6/2023. RN I stated she thought she had taken approximately11 tablets total from 3 different residents during that time. RN I stated she was in the Tennessee Professional Assistance Program (TNPAP) when she was hired at the facility and had informed the facility. RN I stated that she had taken the medications for her personal use and after being terminated from the facility had gone into an inpatient rehabilitation. During an interview on 4/22/2025 at 8:50 AM, the DON stated she had conducted routine audits of the narcotic sheets and noticed some suspicious entries. Residents were immediately assessed to ensure pain was controlled and if the residents had missed any medication doses. RN I was immediately suspended pending an investigation. The DON stated she was aware RN I was part of the TNPAP program and the nurse did not have any narcotic restrictions. During an interview on 4/22/2025 at 9:30 AM, Resident #52 stated she had not had any issues with obtaining pain medications.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observations, and interviews the facility failed to provide adequate personal hygiene and bathing for 2 of 4 residents (Resident #81 and Resident #131) reviewed for Activities of Daily Living (ADL's). The findings include: 1. Review of the undated facility policy titled, Bathing, revealed .It is the policy of the facility to make every effort to respond to the residents' requests and needs .It is the policy of this facility to promote cleanliness . The residents will be offered the required number of showers each week as per regulations . 2. Review of the medical record revealed Resident # 81 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Gastrostomy, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident # 81 was cognitively intact. Resident required substantial/maximal assistance with bathing and dependent on staff to perform transfers. Review of the Care Plan dated 3/27/2025, revealed .requires assist with ADL's .Prefers bed baths over showers . Review of the facility's form titled, Shower List 3B, revealed Resident #81 was scheduled to have showers on Tuesdays and Fridays. Review of the .Documentation Survey Report . Certified Nursing Assistant (CNA) Bathing Task for March 2025 and April 2025, revealed Resident #81 did not receive a shower or bath on the following days: 3/1/2025, 3/2/2025, 3/5/2025, 3/6/2025, 3/8/2025, 3/12/2025, 3/16/2025, 3/27/2025, 3/28/2025, 3/29/2025, 3/30/2025, 3/31/2025, 4/2/2025, 4/3/2025, 4/5/2025, 4/6/2025, 4/7/2025, 4/9/2025, 4/11/2025, 4/13/2025, 4/14/2025, 4/16/2025, 4/17/2025, 4/20/2025, and 4/21/2025. Review of the medical record revealed no documentation for shower or bed bath on 3/3/2025, 3/9/2025, 3/13/2025, 3/17/2025, 3/19/2025, 3/20/2025, 3/23/2025, 3/26/2025, 4/10/2025, and 4/19/2025. The facility was unable to provide documentation that Resident #81 was offered a shower or provided bathing for 35 out of 53 days reviewed. Observation in the Resident's room on 4/21/2025 at 3:25 PM, 4/22/2025 at 7:56 AM and 11:36 AM, 4/23/2025 at 8:14 AM and 4/24/2025 at 11:17 AM, revealed strong foul smell of body odor. 3. Review of the medical record revealed Resident #131 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Diabetes, and Chronic Obstructive Pulmonary Disease. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 5, which indicated Resident #131 was severely cognitively impaired without behaviors. Resident required substantial/maximal assistance with bathing and dependent on staff to perform transfers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Care Plan dated 2/5/2025, revealed .requires assist for ADL's .The resident will receive necessary level of ADL care as needed . Review of the facility form titled, Shower List 3B, revealed Resident #131 was scheduled to have showers on Monday and Thursday night shift. Review of the .Documentation Survey Report . CNA Bathing Task for March 2025 and April 2025, revealed a shower or bed bath was documented as not applicable on 3/1/2025, 3/2/2025, 3/4/2025, 3/8/2025, 3/10/2025, 3/14/2025, 3/15/2025, 3/16/2025, 3/27/2025, 3/29/2025, 3/30/2025, 4/1/2025, 4/2/2025, 4/3/2025, 4/4/2025, 4/6/2025, 4/7/2025, 4/13/2025, 4/15/2025, 4/16/2025, 4/20/2025, 4/21/2025, and 4/22/2025. Review of the medical record revealed, no documentation for shower or bed bath on 3/3/2025, 3/5/2025, 3/9/2025, 3/11/2025, 3/12/2025, 3/17/2025, 3/19/2025, 3/20/2025, 3/23/2025, 3/26/2025, 4/9/2025, 4/10/2025, 4/17/2025, and 4/19/2025. The facility was unable to provide documentation that Resident #131 was offered bathing for 37 out of 53 days reviewed. Observations in resident's room on 4/21/2025 at 3:25 PM, 4/22/2025 at 7:56 AM, 4/22/2025 at 4:03 PM, 4/23/2025 at 8:14 AM, 4/24/2025 at 11:17 AM, revealed strong foul smell of body odor and dirty disheveled hair. 4. During an interview on 4/23/2025 at 4:24 PM, the Director of Nursing (DON) confirmed that residents should be offered a shower on their shower date and that it should be documented if care was provided or refused. During observation and interview with Licensed Practical Nurse (LPN) HH on 4/24/2025 at 11:17 AM, in both resident's room, LPN HH was asked if she noticed any odors, LPN HH stated, .a stinky smell . LPN HH confirmed that the smell could be body odor and stated, .I can't tell which one (Resident) .

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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** Based on facility policy review, medical record review, and interviews, the facility failed to follow a physician's order related to narcotic medication administration for 4 residents (Resident #917, #66, #908, and #909) of 13 residents reviewed for narcotic medication administration. The findings include: 1. Review of the facility's policy titled, Administering Medications, dated 2001 (exact date unknown), revealed .medications must be administered in accordance with the orders, including time frame . 2. Review of the medical record revealed Resident #917 was admitted to the facility on [DATE], with diagnoses including Chronic Pain, Muscle Weakness, and Osteoarthritis. Review of the comprehensive care plan for Resident #917 dated 3/5/2025, revealed Resident #917 was at risk for pain with interventions to observe for pain with medication side effects every shift. Review of a Physician's Order for Resident #917 dated 3/10/2025, revealed an order for Hydrocodone-Acetaminophen (APAP) (narcotic pain-relieving medication)10-325 milligrams (MG) administer 1 tablet by mouth every 8 hours as needed (PRN) pain. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #917 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was moderately cognitively impaired. The resident required staff set up/ clean up assistance with eating and staff supervision or touching assistance with personal hygiene. Further review revealed the resident received opioid medications for pain. Review of a Controlled Drug Administration Record for Resident #917 dated 3/11/2025 - 3/15/2025, revealed the Hydrocodone-APAP 10-325 MG medication was administered by Licensed Practical Nurse (LPN) DD on 3/14/2025 at 6:00 PM, 3/15/2025 at 12:00 AM (6 hours after previous dose), and 3/15/2025 at 6:00 AM (6 hours after previous dose). Further review revealed the pain-relieving medication (Hydrocodone-APAP) was administered every 6 hours and was not administered every 8 hours as ordered by the physician. Review of the monthly Treatment Administration Record for Resident #917 dated 3/2025, revealed the resident had no medication side effects to include sedation or drowsiness. 3. Review of the medical record revealed Resident #66 was admitted to the facility on [DATE], with diagnoses including Left Femur Neck Fracture, Dementia, and Thoracic Spondylosis. Review of a significant change MDS assessment dated [DATE], revealed Resident #66 scored a 1 on the BIMS assessment which indicated the resident was severely cognitively impaired. Further record review revealed the resident received opioid medications. Review of the comprehensive care plan for Resident #66 revised 10/3/2024, revealed the resident was at risk for pain with interventions in place. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Physician's Order for Resident #66 dated 10/17/2024, revealed an order for Hydrocodone -APAP 5-325mg 1 tablet every 12 hours as needed for pain X (times) 14 days (to end on 10/31/2024). Review of a Physician progress note for Resident #66 dated 11/7/2024, revealed .patient has no complaints . Continue pain management with Tylenol 650 mg T.I.D. [three times daily], tramadol 25 mg T.I.D . Review of the facility's document titled, Medication Occurrence Form, dated 11/7/2024 revealed . Hydrocodone given on 11/1/2024, 11/2/2024, 11/3/2024, 11/4/2024, and 11/6/2024 without .physician's order .NP [Nurse Practitioner [eval [evaluate] .no adverse outcome to resident .meds [medications] were replaced . nurse suspended .terminated at end of investigation . Review of a Social Services progress note for Resident #66 dated 11/8/2024, revealed .Resident did not appear to be in any distress or discomfort at this time . Review of a NP progress note for Resident #66 dated 11/8/2024, revealed .Left hip pain .Currently she is on tramadol 25 mg 3 times a day scheduled in addition to Tylenol 650 mg 3 times a day .She is noted with improved status of discomfort and currently she is pleasant and interactive without any distress . Review of the Medication Administration Record (MAR) for Resident #66 dated 11/1/2024 - 11/30/2024, revealed the resident was monitored every shift for pain and was treated with the Tylenol or Tramadol. 4. Review of the medical record revealed Resident #908 was admitted to the facility on [DATE], with diagnoses including Dementia, Malignant Neoplasm of Colon, and Left Intertrochanteric Femur Fracture. Review of a Physician's Order dated 10/29/2024 for Resident #908 revealed Ativan 0.5 mg tablet Give 0. 25mg per oral (by mouth) (PO) twice daily for increased anxiety. Review of a Controlled Drug Administration Record #908 dated 10/30/2024, revealed the Ativan was administered by LPN J on 11/1/2024 11:00 PM, 11/2/2024 4:00 AM (5 hours later), on 11/2/2024 11:00 PM, and 11/3/2024 4:00 AM (5 hours later). Further review revealed the Ativan was administered 5 hours apart, were not due at those times, LPN J had administered extra doses of the Ativan and did not follow the physician orders to administer as twice daily. Review of the facility's document titled, Medication Occurrences Reporting Form dated 11/7/2024 for Resident #908 revealed, .nurse [LPN J] signed out medications [Ativan] at times not supported by order according to narc [narcotic] sheet .NP eval .no adverse outcomes to resident . Review of a Social Services progress note for Resident #908 dated 11/8/2024, revealed .Resident did not appear to be in any distress or discomfort at time of visit .No noted concerns by staff at this time . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #908 scored an 8 on the BIMS assessment which indicated the resident was moderately cognitively impaired. The resident required set up/ clean up assistance from staff with eating. The resident required partial/ moderate staff assistance with personal hygiene. Further review revealed the resident received scheduled pain medication, antianxiety medication, and opioid medication. Review of a comprehensive care plan for Resident #908 dated 11/24/2024, revealed .resident does receive antianxiety medications .observe for lethargy .drowsy .hard to arouse .notify MD/NP [Medical Doctor/Nurse Practitioner] immediately . 5. Review of the medical record revealed Resident #909 was admitted to the facility on [DATE], with diagnoses including Dementia, Generalized Muscle Weakness, and Dysphagia. Review of the physician's order for Resident #909 dated 5/14/2024, revealed .Trazodone 50 mg tablet Give 0. 25mg by mouth at bedtime for depression . Review of a quarterly MDS assessment dated [DATE], revealed Resident#909 scored a 4 on the BIMS assessment which indicated the resident was severely cognitively impaired. The resident required partial/ moderate assistance from staff with eating. The resident required substantial/ maximal staff assistance with personal hygiene. Further review revealed the resident received antidepressant and opioid pain medications. Review of the Controlled Drug Administration Record for Resident #909 dated 11/2/2024, revealed LPN J administered Trazodone 25 mg at 2:00 AM. Further review revealed that LPN J did not follow physician's order prescribed for medication to be given at bedtime. Review of the facility's document titled, Medication Occurrence Reporting Form, dated 11/7/2024 for Resident #908 revealed .trazodone given at 2:00 AM without order according to narc sheet .NP eval .no adverse outcome to resident .meds replaced . Review of a NP progress note for Resident #909 dated 11/8/2024, revealed .stable and she does not appear to be in any acute distress . Generalized pain and discomfort . Review of a Social Services progress note for Resident #909 dated 11/8/2024, revealed .Resident was pleasant and smiling .did not appear to be in any distress or discomfort at this time .No concerns noted by nursing staff at this time . Review of a Nurse progress note for Resident #909 dated 11/9/2024, revealed .No acute discomfort or pain observed . Review of the comprehensive care plan for Resident #909 revised 11/14/2024, revealed .receiving psychotropic medications .for antidepressant .monitor for any side effects and notify to NP/MD . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6. During a telephone interview on 4/23/2025 at 8:34 AM, the Medical Director (MD) stated LPN DD did not follow the ordered parameters for administering Resident #917's Hydrocodone-APAP when she administered the medication every 6 hours instead of every 8 hours which resulted in medication errors. The MD stated Resident #917 was assessed and had no adverse outcome for the medication errors. The MD stated he expected the nurses to follow the physician's orders when administering medications to the residents to prevent medication errors. During a telephone interview on 4/23/2025 at 8:45 AM, the MD stated that LPN J did not follow physician's orders when administering Hydrocodone to Resident #66, Ativan to Resident #908, and Trazodone to Resident #909. The MD stated Residents #66, #908, and #909 were assessed and had no adverse outcomes for the medication errors. The MD stated that he expected the nurses to follow physician's orders when administering medications to residents to prevent medication errors. During an interview on 4/23/2025 at 9:35 AM, the Administrator confirmed LPN DD signed acknowledgement she had administered the Hydrocodone-APAP to Resident #917 every 6 hours instead of every 8 hours on 3/15/2025 which resulted in 2 medication errors. The Administrator stated it was the facility's expectation the licensed nurses follow physician orders when administering medications. During an interview on 4/23/2025 at 9:45 AM, the Administrator confirmed LPN J signed to acknowledge she administered Hydrocodone 5 times to Resident #66 after the medication had been discontinued resulting in 5 medication errors, administered Ativan to Resident #908 at nonscheduled time resulting in 4 medication errors, and Trazodone to Resident #909 at nonscheduled time resulting in 1 medication error. The Administrator stated it was the facility's expectation the licensed nurses follow physician orders when administering medications.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical records review, observations, and interview, the facility failed to follow physician orders for 1 of 3 (Resident #493) sampled residents. The findings include: 1. Review of the facility policy titled, Administering Medications, dated 2001, revealed .Medications .shall be administered in a safe and timely manner, and as prescribed .Medications must be administered in accordance with the orders . Review of the undated facility policy titled, Oxygen Administration, revealed .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physicians order .Review the physician's order .for oxygen administration . 2. Review of the medical record revealed Resident #493 was admitted to the facility on [DATE], with diagnoses including Volvulus (an obstruction due to twisting or knotting of the gastrointestinal tract), Diabetes, Dysphagia, Colostomy, Dementia, and Heart Failure. Review of the annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 9, which indicated moderate cognitive impairment. Review of Care Plan dated 4/16/2025 revealed .Administer medication as prescribed, as tolerated .oxygen as ordered/ tolerated . Physician's Orders dated 4/11/2025 revealed .Oxygen 2 L/min per nasal cannula as needed . Observation in the resident's room on 4/21/2025 at 11:53 AM, on 4/22/25 at 8:01 AM, on 4/23/2025 at 8:21 AM, revealed the resident's oxygen set at 4 liters. During an interview on 4/23/25 at 4:44 PM, the Director of Nursing confirmed that physician's orders be followed regarding oxygen settings. During an interview on 4/24/2025 at 9:22 AM, RN FF confirmed that Resident #493's oxygen order was for 2 Liters and stated, .He shouldn't be on 4 liters .I will change that right now .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to properly destroy narcotic medications for 1 resident (Resident #918) of 13 residents reviewed for narcotic medication use. The findings include: 1. Review of the facility's undated policy titled, Controlled Substances, revealed .controlled substances shall be destroyed/ wasted in the presence of 2 licensed nurses and documentation to reflect as such . 2. Review of the medical record revealed Resident #918 was admitted to the facility on [DATE], with diagnoses including Right Pubis (Pelvis) Fracture, Muscle Weakness, and Osteoarthritis. Review of the comprehensive care plan for Resident # 918 dated 2/22/2025, revealed the resident was at risk for pain with interventions to observe for pain with medication side effects every shift. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #918 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. The resident required staff set up/ clean up assistance with eating and personal hygiene. Further review revealed the resident received opioid medications for pain. Review of a physician's order for Resident #918 dated 3/13/2025, revealed an order for Hydrocodone-Acetaminophen (APAP) (narcotic pain-relieving medication) 7.5-325 milligrams (MG) administer 1 tablet by mouth every 4 hours as needed (PRN) for pain. Review of a Controlled Drug Administration Record for Resident #918, revealed the following recorded entries for the Hydrocodone-APAP 7.5-325 MG medication: .date .3/13 [2025] .time .1800 [6 PM] .amt [amount] used .0 [tablet] .amt wasted .1 [tablet] .witnessed [blank] .admin [administered] by .[Licensed Practical Nurse (LPN) DD] .wasted [handwritten by LPN DD] .amt rem [remaining] .18 [tablets] .date .3/13 [2025] .time .1830 [6:30 PM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .17 .3/13 [2025] .2100 [9:00 PM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .16 .3/13 [2025] .2130 [9:30 PM] . amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .15 .3/13 [2025] .2200 [10:00 PM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] . wasted [handwritten by LPN DD] .amt rem .14 .3/13 [2025] .2230 [10:30 PM] .amt used .0 .amt wasted .1 . witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .13 .3/13 [2025] .2300 [11 PM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] . amt rem .12 . 3/13 [2025] .2230 [11:30 PM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .11 .3/14 [2025] .0000 [12 AM] .amt used .0 .amt wasted .1 . witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .10 .3/14 [2025] .0030 [12:30 AM] .amt used .0 .amt wasted .1 .witnessed [blank] .admin by .[LPN DD] .wasted [handwritten by LPN DD] .amt rem .9 . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 4/22/2025 at 5:31 PM, LPN EE stated she worked night shift on 3/13/2025 through 3/14/2025 with LPN DD (assigned on the adjacent hallway). LPN EE stated LPN DD did not ask her to witness the destruction or waste of the narcotic medications for Resident #918 at any time during her shift on 3/13/2025 through 3/14/2025. During a telephone interview on 4/23/2025 at 8:34 AM, the Medical Director (MD) stated he expected the nurses to follow the facility's policy for narcotic medication destruction which included destroying or wasting the narcotic medication with a witness. During an interview on 4/23/2025 at 9:35 AM, the Administrator confirmed LPN DD did not follow the facility's policy for narcotic medication destruction when LPN DD failed to destroy or waste Resident #918's Hydrocodone-APAP medication multiple times on 3/13/2025 through 3/14/2025.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the policy review, medical record review, observation, and interview, the facility failed to ensure medications were properly stored when there was opened and undated medication on 1 of 19 (medication cart 1B) med storage areas. The findings include: 1. Review of the facility's policy titled, Medications Storage, non dated, revealed .It is the policy of the facility that medications and biologicals are stored securely and properly following manufacturer's recommendations or those of the supplier .Outdated, contaminated, or deteriorated medications containers that are cracked, soiled, or without secure closures and removed from stock, disposed of according to procedure for medication disposal and reordered from the pharmacy . 2. Review of the medical record revealed Resident #172 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease and Depression. Review of Minimum data Set (MDS) dated [DATE], revealed a Brief interview for Mental Status (BIMS) score of 15, which indicated Resident #172 had intact cognition. Review of the physician order dated 7/24/2024, revealed .Ipratropium-Albuterol Solution [a combination of bronchodilators that are breathed in through the mouth to open up the air passages in the lungs] 0.5-2.5 (3) MG [milligram]/3ML [milliliter] 3 ml inhale orally via [by] nebulizer every 6 hours for Bronchospasm . Observation during med pass at the 1b med cart on 4/22/2025 at 3:04 PM, revealed LPN DD an opened and undated Ipratropium-Albuterol Solution (individual plastic vials of breathing treatment). LPN confirmed the Ipratropium-Albuterol Solution box and aluminum packaging was opened and needed an open date. LPN DD asked LPN Manager U what to do since the aluminum package and box had no open date. LPN Manager U stated .dispose . LPN DD put the Ipratropium-Albuterol Solution (individual plastic vials of breathing treatment) in the trash bag on the med cart. During an interview on 4/ 4/22/2025 at 3:58 PM, LPN Manager U confirmed the med cart's trash bag is not an appropriate place to dispose the Ipratropium-Albuterol Solution. During an interview, in the conference room, on 4/23/2025 at 4:24 PM Director of Nurses (DON) confirmed the Ipratropium-Albuterol Solution packaging should not be opened and undated.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, and interview, the facility failed to provide dental services for 1 of 2 (Resident #130) reviewed for dental services. The findings include: 1. Review of the facility's undated policy titled, Dental Services, revealed Routine dental services are provided to our residents through .A contract agreement with a licensed dentist that comes to the facility . Referral to the resident's personal dentist .Referral to community dentists or Referral to other health care organizations that provide dental services .Routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care .Social services representative will assist residents with appointments, transportation arrangements .Direct care staff will assist residents with denture care .All dental services provided are recorded in the residents medical record . 2. Review of the medical record revealed Resident #130 was admitted to the facility on [DATE], with diagnoses including of Hemiplegia/Hemiparesis, Cerebral Atherosclerosis, Atrial Fibrillation, and Anemia. Review of the facility's Transportation Scheduling List for February 2025 revealed .[Named Resident #130] . 2:00 PM .Appointment with [Named Dentist] .Transport With .Van . Review of the facility's ancillary services February 2025 calendar revealed dental onsite clinic scheduled for 2/7/2025, and again on 2/20/2025. Review of a [named dental service] Progress Note dated 2/7/2025 revealed .Not Seen Resident was not seen because . resident did not present to clinic. Review of the facility's ancillary services March 2025 calendar revealed dental hygienist [dental assistant] onsite clinic scheduled for 3/10/2025. Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed Resident #130 had a Brief Interview for Mental Status Score (BIMS) of 14, indicating the resident was cognitive intact and required set up for oral and personal hygiene. Review of the facility's ancillary services April 2025 calendar revealed dental hygienist onsite clinic scheduled for 4/4/2025. Review of the Care Plan dated 4/3/2025 revealed .at risk for oral/dental health problems r/t [related to] missing teeth .Observe for s/sx [signs and symptoms] of oral/dental problems .Pain .toothache .Abscess . Teeth missing, loose, broken, eroded, decayed .Provide mouth care as tolerated . Review of a [Named Dental Service] dated 4/15/2025 confirmed Resident #130 was on the dental hygienist list to be seen. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a [Named Dental Service] Progress note dated 4/15/2025 revealed .Not seen Resident was not seen, not brought to dentist. Review of the medical record revealed the facility was unable to provide documentation that Resident #130 had been seen by a licensed dentist for her increasing dental concerns since 7/23/2024. During observation and interview in Resident #130's room on 4/21/25 at 4:05 PM, Resident#130 stated, I was told I had good dental insurance when I came here and I have been having trouble with my teeth and I have not seen the dentist yet, my teeth are bad and my mouth hurt sometimes . During an interview on 4/22/25 at 2:58 PM, the Social Service Director (SSD) confirmed that there is a dental service that comes onsite to give dental care to residents and that the residents or family representative signs an agreement upon admission or at any time and they are added to the dental list. The SSD confirmed that residents may also seek offsite dental services if they chose to. The SSD confirmed Resident #130 had some teeth extracted in the past by the onsite dental service. The SSD was asked who is responsible to ensure residents get to their onsite dental appointments. The SSD confirmed that floor staff are to make sure residents get to their appointments. The SSD was asked to read a [named dental service] dental progress note and to explain what it meant when it stated, resident did not present to clinic or resident was not brought to clinic. The SSD stated, I can't recall . During an interview on 4/23/25 at 2:45 PM, the Administrator confirmed it is a collaboration of the interdisciplinary team (all staff) to ensure residents make it to dental appointments and along with ensuring that residents are rescheduled if appointments are missed.

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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 medical record review, and interview, the facility failed to maintain accurate medical records related to dental appointments for 1 of 2 (Resident #130) reviewed for dental services. The findings include: 1. Review of the facility's undated policy titled, Dental Services, revealed .Social services representative will assist residents with appointments, transportation arrangements .Direct care staff will assist residents with denture care .All dental services provided are recorded in the residents medical record . 2. Review of the medical record revealed Resident #130 was admitted to the facility on [DATE], with diagnoses including of Hemiplegia/Hemiparesis, Cerebral Atherosclerosis, Atrial Fibrillation, and Anemia. Review of the significant change Minimum Data Set (MDS) dated [DATE], revealed Resident #130 had a Brief Interview for Mental Status Score (BIMS) of 14, indicating the resident was cognitive intact and required set up for oral and personal hygiene. Review of the facility's Transportation Scheduling List for February 2025 revealed .[Named Resident #130] . 2:00 PM .Appointment with [Named Dentist] .Transport With .Van . Review of the facility's ancillary services February 2025 calendar revealed dental onsite clinic scheduled for 2/7/2025 and again on 2/20/2025. Review of a [named dental service] Progress Note dated 2/7/2025 revealed .Not Seen Resident was not seen because . resident did not present to clinic. Review of the facility's ancillary services April 2025 calendar revealed dental hygienist onsite clinic scheduled for 4/4/2025. Review of the Care Plan dated 4/3/2025, revealed .at risk for oral/dental health problems r/t [related to] missing teeth .Observe for s/sx [signs and symptoms] of oral/dental problems .Pain .toothache .Abscess . Teeth missing, loose, broken, eroded, decayed .Provide mouth care as tolerated . Review of a [Named Dental Service] dated 4/15/2025, confirmed Resident #130 was on the dental hygienist list to be seen. Review of a [Named Dental Service] Progress note dated 4/15/2025, revealed .Not seen Resident was not seen, not brought to dentist. Review of the medical record revealed the facility was unable to provide documentation that Resident #130 failed to show up for dental appointments. (continued on next page)

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	445183	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gallatin Center for Rehabilitation and Healing	438 North Water Ave Gallatin, TN 37066

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/22/25 at 2:58 PM, the Social Service Director (SSD) was asked to read a [named dental service] dental progress note and to explain what it meant when it stated, resident did not present to clinic or resident was not brought to clinic. The SSD stated, I can't recall . During an interview on 4/23/25 at 2:45 PM, the Administrator confirmed that documentation should be in the resident's medical record when residents are unable to present to the dental clinic for appointments and should be rescheduled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 1 of 6 staff members (Licensed Practical Nurse (LPN) DD) failed to disinfect reusable equipment before use and after use and failed to properly perform hand hygiene. When 2 of 2 staff members (Certified Nurse Assistant (CNA) EE and Registered Nurse (RN) FF) failed to wear Personal Protective equipment (PPE) in a Contact Isolation room and during direct care in an Enhanced Barrier Precautions room. The findings include: 1. Review of the undated facility's policy titled, HAND HYGIENE, revealed .This facility considers hand hygiene the primary means to prevent the spread of infections .Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations .When hands are visibly soiled .After patient care encounter and/or hand sanitizer .After contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus, salmonella, shigella and C. difficile .The use of gloves does not replace hand washing/hand hygiene . Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 2001, revealed .Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected using appropriate cleaning/disinfecting agents as required .Non-critical items are those that come in contact with intact skin but not mucous membranes .Reusable items are cleaned and disinfected or sterilized between residents .stethoscopes, durable medical equipment . Review of the undated facility's policy titled, Nebulizer Treatment Protocol, revealed .This policy is to instruct the proper use of aerosolized medications to the lower airways via small volume nebulizer .Rinse medication nebulizer after each use and change routinely and as needed . Review of the undated facility's policy titled, Enhanced Barrier Precautions, revealed .Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use in addition to standard precautions during high contract resident care activities .EBPs are indicated for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .Wounds generally include chronic wounds .Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies. Peripheral IV catheters are not considered an indwelling medical device for purpose of EBPs . Review of the facility's policy titled, Medications Storage, non dated, revealed .It is the policy of the facility that medications and biologicals are stored securely and properly following manufacturer's recommendations or those of the supplier .Outdated, contaminated, or deteriorated medications containers that are cracked, soiled, or without secure closures and removed from stock, disposed of according to procedure for medication disposal and reordered from the pharmacy . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Isolation - Categories of Transmission-Based Precautions, dated 2001, revealed Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. Implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact. 2. Review of the medical record revealed Resident #172 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease and Depression. Review of quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief interview for Mental Status (BIMS) score of 15, which indicated Resident #172 had intact cognition. Review of the physician order dated7/24/2024, revealed .Ipratropium-Albuterol Solution [a combination of bronchodilators that are breathed in through the mouth to open up the air passages in the lungs] 0.5-2.5 (3) MG [milligram]/3ML [milliliter] 3 ml inhale orally via [by] nebulizer every 6 hours for Bronchospasm . Observation during med pass, at 1b med cart on 4/22/2025 at 3:04 PM, revealed LPN DD touched her face, failed to perform hand hygiene, gather the resident's items, and entered the resident's room. LPN DD gave the oral medication, removed the pulse oximeter (ox-a device, placed on the finger, used to measure oxygen saturation) out of her pants pocket and place it on the resident's right finger. LPN failed to disinfect the pulse ox before use. LPN DD used the stethoscope to listen to the resident's lung sounds and placed the stethoscope around her neck. LPN DD connected the nebulizer tubing to the machine, opened and poured the medication in the nebulizer, and started the machine. After the completion of the treatment, LPN DD failed to disconnect and rinse the mouthpiece and place it on a barrier to dry before placing it in a clear plastic bag. LPN DD removed the stethoscope from around her neck and removed the pulse ox from her pocket, listened to the resident's lung sounds and placed the pulse ox on the resident's finger. LPN DD failed to clean the stethoscope and the pulse ox before use. LPN DD returned to the med cart, used an alcohol pad to wipe the stethoscope and placed the pulse ox in her pocket. LPN DD failed to properly disinfect the stethoscope and pulse ox after use. 3. Review of the medical record revealed Resident #181 was admitted to the facility on [DATE], with diagnoses including Clostridium Difficile, Diarrhea, and Psychosis. Review of the admission MDS dated [DATE], revealed a BIMS score of 7, which indicated Resident #181 had severely impaired cognition. Review of the physician order dated 4/18/2025, revealed Resident #181 had an order for Contact isolation related to Clostridium Difficile (c-diff a bacterium that causes an infection, a symptom is usually diarrhea). Review of the physician order dated 4/21/2025, revealed Resident #181 had an order Vancomycin [an antibiotic, used to kill bacteria or prevent its growth] for c-diff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview during dining on 4/22/2025 at 7:51 AM, revealed CNA EE entered Resident #181's room with no PPE on, left the door opened, placed the meal tray on the resident's over the bed table, rearranged and placed the resident's bed sheet on the resident, used the bed remote to raise the head of bed, pushed the over the bed table closer to the resident. CNA EE removed the lid from the meal tray, opened the resident's juice and yogurt. CNA EE failed to perform hand hygiene after touching potentially contaminated objects. CNA EE confirmed the resident had a contact precautions signage on the door and a gown and gloves should have been worn before the room was entered. CNA EE confirmed staff should remove and dispose of PPE inside the contact isolation room and perform hand hygiene before leaving. CNA EE failed to wear PPE in a contact isolation room and failed to perform hand hygiene after touching potentially contaminated items. 4. Review of the medical record revealed Resident #393 was admitted to the facility on [DATE], with diagnoses including Infection to Right Knee and Diabetes. Review of the admission MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #393 had intact cognition. Resident #393 had a PICC line (Peripherally Inserted Central Catheter, used as a route of medication through the veins). Review of the physician order dated 4/15/2025, revealed . Enhanced Barrier Precautions every day and night shift for PICC. Review of the physician order dated 4/17/2025, revealed .Change PICC [peripherally inserted central catheter] dressing once weekly .every Mon [Monday] AND as needed . Review of the physician order dated 4/17/2025, revealed Resident #393 had an order for Ceftriaxone [an antibiotic] to be given intravenously (iv) one time a day for right knee prosthetic joint infection. Review of the physician order dated 4/18/2025, revealed ' .Venofer Intravenous Solution 20 MG[milligram]/ML [milliliter] (Iron Sucrose) Use 100 mg intravenously one time a day for supplement for 5 Days . A random observation in the resident's room on 4/23/2025 at 8:38 AM, revealed. RN FF connected Resident #393's iv tubing to the PICC line with no gown on. RN FF failed to wear proper PPE during direct care at the resident's PICC line. During an interview on 4/23/2025 at 8:47 AM, RN FF was asked should a gown and gloves be worn during care at a PICC line. RN FF stated, No. During an interview, in the conference room, on 4/23/2025 at 4:04 PM and 4:16 PM, the Director of Nurses (DON) confirmed staff should wear a gown and gloves when entering a resident's room who is on contact isolation. The DON confirmed residents with wounds, foley catheters, a picc line or midline should be on enhanced barrier precautions and staff should wear a gown and gloves when providing direct care or in close contact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, in the conference room, on 4/23/2025 at 4:24 PM Director of Nurses (DON) confirmed the stethoscope and pulse ox should be cleaned before and after use with sanitizing wipes. The DON confirmed when removed from a staff 's pocket, the pulse ox should be cleaned before use.