| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 445492 | A. BUILDING _____ B. WING _____ | 03/11/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| RIPLEY HEALTHCARE AND REHAB CENTER | 118 HALLIBURTON DRIVE RIPLEY, TN 38063 |

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 0698<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Past noncompliance - remedy proposed**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on [MEDICAL TREATMENT] Transfer Agreement, facility policy review, facility Diet and Nutrition Care Manual, medical record review, observation, and interview, the facility failed to provide appropriate care and services related to transportation and dietary communication for 3 of 3 sampled residents (Resident #19, #32, and #52) reviewed receiving [MEDICAL TREATMENT]. The findings include: Review of the facility's policy titled, Transportation, dated 8/2014, showed, .Our facility shall help arrange transportation for residents as needed . Review of the facility's NURSING HOME [MEDICAL TREATMENT] TRANSFER AGREEMENT, dated 2009, showed, .Facility shall have the responsibility for arranging suitable transportation of the Designated Resident to and from the Center .Treatment presently being provided to the Designated Resident, including .diet or fluid intake . Review of the facility's Diet and Nutrition Care Manual .[MEDICAL TREATMENT] Diet, dated 2019, showed, .Individuals placed on this diet are often limited in the amount of sodium, fluid, potassium and phosphorus they can consume .Limit added sugars/saturated fats, reduce sodium .Honor food preferences . 1. Review of the medical record, showed Resident #19 had a [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].Resident has [MEDICAL TREATMENT] on (Tuesday, Thursday and Saturday) .related to end stage renal . Review of the quarterly Minimum Data Set ((MDS) dated [DATE], showed Resident #19 had a brief interview of mental status (BIMS) of 15, which indicated she was cognitively intact. Review of the Progress Notes dated 2/22/2020, showed, .No one showed to pick resident up for [MEDICAL TREATMENT] .called (Named [MEDICAL TREATMENT] Clinic) .was informed that they had called (Named Transportation Services) yesterday to make sure she was on their list for pickup and that she was but when talking to the driver today they said that she was not . During an interview conducted on [DATE]20 at 10:54 AM, Resident #19 stated, .go to [MEDICAL TREATMENT] Tuesday, Thursday and Saturday .missed one Saturday about a month ago .transportation said I wasn't on the list . During an interview conducted on 3/10/2020 at 3:00 PM, Certified Nursing Assistant (CNA) #2 stated, Yes, ma'am they just didn't show up to get her .they didn't have a van to come pick her up . During an interview conducted on 3/10/2020 at 4:42 PM, the Assistant Director of Nursing (ADON) confirmed Resident #19 missed her [MEDICAL TREATMENT] appointment. The ADON stated, .we have this problem .we get everything ready and set up and they say they are having staffing issues . During an interview conducted on 3/11/2020 at 8:21 AM, the Director of Nursing (DON) was asked if Resident #19 missed her [MEDICAL TREATMENT] appointment. The DON stated, .Yes .2/22(2020) . The DON was asked what happened. The DON stated, .according to the notes transportation didn't show up . 2. Review of the medical record, showed Resident #32 had [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].Controlled Carbohydrates Diet .renal .Resident has [MEDICAL TREATMENT] on .Tuesday, Thursday, and Saturday . Review of the quarterly Minimum Data Set ((MDS) dated [DATE], showed Resident #32 had a brief interview of mental status (BIMS) of 15, which indicated she was cognitively intact. During an interview conducted on [DATE]20 at 11:20 AM, Resident #32 stated, I'm on a very strict diet .renal .half the time I may have one thing on my ticket that's really on my plate . Review of Resident #32's meal ticket dated 3/10/2020, showed, .Ziti Noodles (plain buttered noodles) . Observation in the Dining Room on 3/10/2020 at 12:34 PM, showed Resident #32 had Baked Ziti with tomato sauce on her meal tray. During an interview conducted on 3/11/2020 at 8:10 AM, the Dietary Manager and the District Manager were asked should Resident #32 receive tomato based sauces on her meal tray. The Dietary Manager stated, She can't have that. The Dietary Manager confirmed that Resident #32 should have only been served the ziti noodles and not the Baked Ziti with tomato sauce. During an interview conducted on 3/11/2020 at 9:30 AM, the Registered Dietician (RD) confirmed she had not communicated with the [MEDICAL TREATMENT] RD about Resident #32. The RD was asked should the facility communicate with the [MEDICAL TREATMENT] RD. The RD stated, Definitely . During an interview conducted on 3/11/2020 at 10:18 AM, the Dietary Manager was asked if she communicated with the RD from the [MEDICAL TREATMENT] clinic regarding residents that were receiving [MEDICAL TREATMENT]. The Dietary Manager stated, No. 3. Review of the medical record, showed Resident #52 had a [DIAGNOSES REDACTED]. Review of the physician's orders [REDACTED].Resident has [MEDICAL TREATMENT] on (Tuesday, Thursday and Saturday) . Review of the Progress Notes dated 3/3/2020, showed, .Patient unable to have transportation to [MEDICAL TREATMENT] today . During an interview conducted on 3/10/2020 at 3:10 PM, CNA #2 confirmed Resident #52 missed his appointment because the Transportation Services failed to pick him up. During an interview conducted on 3/11/2020 at 8:21 AM, the DON was asked if Resident #52 missed his [MEDICAL TREATMENT] appointment. The DON stated, Yes .3/3(2020) .transportation didn't show up .they (staff) should have called EMS (Emergency Medical System) . |
| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on facility policy review, observation, and interview, the facility failed to ensure food was stored and served under sanitary conditions as evidenced by expired, opened, undated, and unlabeled foods in 1 of 1 nourishment refrigerators (Nourishment Room Refrigerator) and 1 of 10 staff members (Certified Nursing Assistant (CNA) #1) inappropriately handled food during dining observations for 4 of 21 residents (Resident #5, #13, #29, and #7) on the 100 Hall. The findings include: Review of the facility's policy titled, Food Storage: Cold Foods, dated ,[DATE], showed, .All foods will be stored, wrapped, or in covered containers, labeled and dated . Review of the facility's policy titled, Assistance with Meals, dated ,[DATE], showed, .All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling . 1. Observation on the 100 Hall on [DATE] at 3:48 PM, in the Nutrition Room refrigerator/freezer showed the following: a. (1) 2-liter bottle of orange soda opened, unlabeled, and undated. b. (1) 2-liter bottle of Dr. Pepper opened, unlabeled, and undated. c. 2 styrofoam cups full of a creamy brown substance opened, unlabeled, and undated. d. 1 piece of plastic wrap with a brown substance noted stuck to the back of the second shelf of the refrigerator, unlabeled, and undated. e. 1 bottle of French salad dressing opened, unlabeled, and undated. f. 1 bottle of ketchup opened, unlabeled, and undated. g. A container of orange sherbet opened, undated, and thawed. h. 2 cartons of milk with expiration dates of [DATE] and [DATE]. i. A frozen dinner unlabeled and undated. During an interview conducted on [DATE] at 4:15 PM, the District Certified Dietary Manager (CDM) confirmed there should not be unlabeled, undated, or expired food in the refrigerator/freezer. 2. Observation on the 100 Hall on [DATE] at 12:09 PM, showed CNA #1 setup Resident #5's meal tray and opened the resident's carton of milk by inserting her index finger into the carton and pulling it open. Observation on the 100 Hall on [DATE] at 8:02 AM, showed CNA #1 setup Resident #13's meal tray and opened the resident's carton of milk, inserted her right index finger into the carton and pulled it open. Observation on the 100 Hall on [DATE] at 8:10 AM, showed CNA #1 setup Resident #29's meal tray and opened the resident's carton of milk, inserted her right index finger into the carton and pulled it open. Observation on the 100 Hall on [DATE] at 8:18 AM, showed CNA #1 setup Resident #7's meal tray and opened the resident's milk carton, inserted her right index finger into the carton and pulled it open. During an interview conducted |

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

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.

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| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>on [DATE] at 10:59 AM, the Director of Nursing (DON) was asked should staff open a milk carton by putting their finger inside the carton and pulling it open. The DON stated, No. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on facility policy review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were followed when 3 of 5 nurses (Licensed Practical Nurse (LPN) #1, #2, and #3) failed to perform hand hygiene for 5 of 9 sampled residents (Resident #22, #29, #153, #5, and #25) during medication administration. The findings include: Review of the facility's policy titled, Handwashing/Hand Hygiene, with a revision date of 2/2018, showed that hand hygiene should be performed before and after direct contact with residents, before preparing and handling medications, after contact with objects in the immediate vicinity of the resident, and after removing gloves. Observation of medication administration in the resident's room on [DATE]20 at 11:30 AM, showed LPN #1 cleaned the glucometer with bleach wipes, donned clean gloves, and failed to perform hand hygiene. LPN #1 administered [MED] to Resident #22, removed gloves, and administered oral medication without performing hand hygiene. Observation of medication administration in the resident's room on [DATE]20 at 4:25 PM, showed LPN #2 moved the over the bed table, touched the quarter side rail of the bed, moved the pillow, and pulled the privacy curtain without performing hand hygiene. LPN #2 donned clean gloves and administered an eye drop to Resident #29's right eye. Observation of medication administration in the resident's room on 3/10/2020 at 8:00 AM, showed LPN #1 administered oral medications to Resident #153 without performing hand hygiene. Observation of medication administration in the resident's room on 3/10/2020 at 10:03 AM, showed LPN #3 removed an old medication patch from Resident #5's left shoulder, cleaned the former site with an alcohol pad, and applied a new medication patch. LPN #3 removed her gloves and administered crushed oral medications to Resident #5 without performing hand hygiene. Observation of medication administration in the resident's room on 3/10/2020 at 12:02 PM, showed LPN #3 moved the privacy curtain, repositioned the pillow, moved the bedside table, turned the water faucet on and off, and failed to perform hand hygiene. LPN #3 donned clean gloves, and administered medication to Resident #25 via an enteral feeding tube without performing hand hygiene. During an interview conducted on 3/11/2020 at 11:22 AM, the Director of Nursing (DON) confirmed that hand hygiene should be performed prior to preparing and handling medications, after contact with objects in the immediate vicinity of the resident, before and after direct contact with residents, and before and after glove use. |