STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445002	A. Building B. Wing	02/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Oakwood	244 Oakwood Dr Lewisburg, TN 37091

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy, medical record review, observation and interview the facility failed to follow the facility accident policy related to an unobserved fall for 1 of 3 (Resident #31) reviewed for accidents. The findings include: 1. Review of the facility policy titled, INCIDENT AND ACCIDENT PROCESS, with revision date of 8/13/2013 revealed, .Investigation into the incident/accident .Obtain information on what happened-what was actually seen or heard. If not witness, get patient's statement about what happened .Never move the patient until the assessment is completed unless immediate treatment is needed .Assess the patient related to the incident/accident . 2. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction, Monocular Vision Loss and Personal history of Traumatic Brain Injury. Review of the Annual Minimum Data Set (MDS) dated [DATE], revealed Resident #31 had a Brief Interview for Mental Status score of 14, which indicated Resident #31 had no cognitive impairment. Continued review of the MDS revealed Resident #31 was dependent for transfers and walking was not attempted. Review of the Fall Scene Investigation Report dated 12/5/2024, revealed Registered Nurse (RN) D and Licensed Practical Nurse (LPN) G were present when Resident #31 fell on [DATE]. Continued review revealed Resident #31 was found face down on the floor with his left leg still in his bed. Further review revealed Resident #31 slipped trying to reach his urinal. Review of a Statement Form dated 12/5/2024 completed by LPN G revealed, .[Named RN D] and I .were in report .CNA [Certified Nursing Assistant] came and stated [Named Resident #31] is on the floor .Both [LPN G and RN D] went immediately to his room .Pt. [patient] was in bed .stated he was trying to reach his urinal on the floor .c/o [complained of] left shoulder and right face and forehead pain .neuro checks in place immediately . The Statement Form revealed Resident #31 had been moved from the floor to the bed prior to nursing staff assessment. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 12/5/2024 ,completed by LPN G revealed, .Approx. [approximately] 7:00 pm Staff found Patient on the floor face down with bil. [bilaterial] lower ext. [extremity] still in the bed; Patient stated he was trying to reach for his urinal which was on the floor and fell ; Staff contacted Nurses on Hall; Nurses immediately went to Patient's room where Staff had already placed Patient back in bed; Nurse performed assessment .Patient c/o of left shoulder and right side of face and forehead pain; neuro checks in place immediately .On-call Physician notified .[Named Physician] responded with a video call with both Nurses and Patient; [Named Physician] decided after talking with Patient that it was best to send him to the ER [emergency room] for evaluation . Review of Hospital #1's Final Report for Resident #31 dated 12/5/2024 revealed, .Patient precented to emergency room by ambulance for complaint of fall at the nursing home patient rolled out of bed and hit the left side of his head he had swelling to his face he was complaining of pain in his left shoulder left knee he denied any loss of consciousness patient is at nursing home for rehab of a large stroke triage .patient was seen and examined we will get a scan of his head face neck we will x-ray his left shoulder left knee we will check basic lab work and will further assess .10:30 PM the patient's scans are read by the radiologist they were interpreted as being nonremarkable patient .sent back to the nursing home . During an interview and observation on 2/11/2025 at 8:26 AM, Resident #31 was dressed in street clothes sitting in his wheelchair. Resident #31 stated, .I had a fall out of the bed once . During an interview on 2/13/2025 at 11:05 AM, RN D was asked if the Certified Nursing Assistants moved Resident #31 from the floor to bed prior to a nurse assessment. RN D stated, .yes, no nurse assessed him before he was placed back in the bed .we always want them to call us first before they move the resident. I told the staff to always call me first not to move the resident .I called the physician, and they elected to send him to hospital due to his past brain injury . During an interview on 2/13/2025 at 4:13 PM, the Director of Nursing (DON) was asked if the CNAs should have moved Resident #31 prior to a nursing assessment. The DON stated, .no, only reason to move the resident would be if he was in immediate danger .

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, and interviews, the facility failed to ensure that 1 of 24 sampled residents (Resident #31) received trauma-informed care in accordance with professional standards of practice and accounting for a resident's experiences and preferences to eliminate or mitigate triggers that may cause re-traumatization of the resident. The findings include: 1. Review of the undated facility policy titled, Care Plan Completion, revealed, .After completing the MDS [Minimum Data Set] and CAA [Care Area Assessment] portions of the comprehensive assessment, the next step is to evaluate the information gained through both assessment processes to identify problems .patient's . problems, and needs . Review of the undated facility policy titled, Trauma Informed Care, revealed, .As an organization we are committed to learning about trauma and its effects and to engage with an implement trauma-informed approaches to the care we provide and the culture we create .Trauma-informed care is an important component of enacting our commitment to person-centered care through which we offer individualized support and services .Residents who have a trauma history deserve access to care that is trauma-sensitive and behavioral health treatment .Our organization can and should have an organizational culture that is trauma-responsive and so avoids retraumatizing residents and creates an environment of safety .We are committed to full implementation of the trauma informed care requirements as codified in the CMS [Centers for Medicare & Medicaid Services] Final Rule-these requirements pertain to comprehensive person-centered care planning . 2. Review of Hospital #2's Discharge Summary for Resident #31 dated 12/20/2019 revealed, .[Named Resident #31] is a [AGE] year-old gentlemen with a history most notable for a gunshot wound on 6/19 [6/19/2019] status post craniotomy, multiple revisions; brain abscesses treated at outside hospital .stroke with residual left-sided weakness .seizure disorder .chronic malnutrition status post PEG [Percutaneous Endoscopic Gastrostomy Tube - feeding tube inserted through the skin and into the stomach] placement who presents to [Named Hospital #2] following a recent discharge with altered mental status and acute monocular vision loss. Patient's prior hospitalization s had all been at [Named Hospital #3] in Memphis Tennessee. Patient was recently discharged from an outside hospital 3 days prior to his admission to [Named Hospital #2] soon after returning home with his fiancee he became more confused, complained of vision loss in his left eye was febrile to 103 [degrees Fahrenheit] . Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction, Monocular vision loss, adjustment disorder with mixed anxiety and depressed mood, and Personal history of Traumatic Brain Injury. Review of the Social Service-Comprehensive assessment dated [DATE] revealed .Does patient have a history of traumatic experiences (describe)? No . Review of the Annual MDS dated [DATE], revealed Resident #31 had a Brief Interview for Mental Status score of 14 which indicated no cognitive impairment. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Social Service-Comprehensive assessment dated [DATE], revealed .Does patient have a history of traumatic experiences (describe)? Patient denied any history of traumatic experiences at this time . Review of the Care Plan with review date of 12/24/2024, revealed no care plan for the history of trauma Resident #31 had experienced. During an interview on 2/11/2025 at 8:23 AM, Resident #31 was asked if he ever experienced any trauma in his life. Resident #31 stated, .I got shot one time .I have pain in my shoulder where I got shot, I have nightmares about it . During an interview on 2/13/2025 at 2:10 PM, Social Service Director (SSD) was asked what the importance of the trauma informed care assessment is. SSD stated, .to inform staff of any triggers after trauma .PCL [Post Traumatic Stress Disorder Checklist to help Social Workers screen clients for potential symptoms of Post Traumatic Stress Disorder] is what we do . SSD was asked if she reviewed Resident #31's history and physical. SSD stated, .not exactly .I do know that his family lives in Memphis .he was placed here for his protection .I didn't admit him . SSD was asked if she was aware Resident #31 was debilitated due to a gun shot. SSD stated, .I have never been told that I assumed it was something .I have never read his history and physical .he could have trauma related to that .I do have multiple progress notes .what he thinks is not reality . SSD was asked if confusion and dementia would keep her from monitoring for post traumatic stress disorder. SSD stated, .I am not questioning that .I am not saying he shouldn't be followed .it is important. I feel like I should have been more in depth with his review .I don't have a PCL on [Named Resident #31] . During an interview on 2/13/2025 at 2:40 PM, MDS Coordinator stated, .I would only mark the MDS for PTSD if there was a diagnosis from the doctor .the HIM [Health Information Manager] would do the coding for diagnosis .I was here when he admitted .his family lives in Memphis .I know he got shot .I would consider that traumatic .I have never witnessed him being upset but there is a potential .he seems ok .I have never asked him about it .he has confusion .I am not sure he remembers it . During an interview in Resident #31's room on 2/13/2025 at 2:50 PM with Resident #31 and the MDS Coordinator. Resident #31 was asked what brought him to the facility Resident #31 stated, .I got shot . Resident #31 was asked where he got shot. Resident #31 stated, .it hit me in the head and shoulder .I was riding around in my car .some guy was acting crazy .my friends told me he was after me .I said I am superman he isn't going to f [expletive curse word] with me then I see an assault rifle, heard it .[NAME] .hit me in shoulder and head ended up in Memphis in the hospital .I am in Lewisburg now . After the interview the MDS Coordinator was asked if it would be important to care plan for trauma informed care on Resident #31 and she stated, yes. During a telephone interview on 2/13/2025 at 4:35 PM Family Member (FM) F was asked how the gunshot wound has affected Resident #31's life. FM F stated, .affected him tremendously .now he is in poor health . the craniotomy affected his cognition .disfigured his sinus cavity .affected his vision .I told the facility about his history .he was admitted with a feeding tube .we never found out who shot him that is why he was moved out of Memphis .I don't even stay in Memphis much due to the fear the shooter may come after me .he had to move away from his whole family .

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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** 38909 Based on policy review, medical record review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection was maintained for 1 of 1 sampled resident (Resident #16) reviewed for enhanced barrier precautions. The findings include: 1. Review of the facility's policy titled, Enhanced Barrier Precautions, dated 4/2024, revealed .Enhanced Barrier Precautions (EPB) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact activities. EPB are used in conjunction with standard precautions and expand the use of PPE [personal protective equipment] to donning of gown and gloves during high-contact patient care activities that provide opportunities for transfer of MDRO to staff hands and clothing .EPB are indicated for patients with .wounds . even if the patient is not known to be infected or colonized with a MDRO .Providers and partners must wear gloves and a gown for the following High Contact Patient Care Activities .Dressing .Bathing .Transferring . Changing Linens .Providing Hygiene .Wound Care: any opening requiring a dressing .Generally, this includes chronic wounds .covered with an adhesive bandage or similar dressing .pressure ulcers .PPE for EBP is only necessary when performing high-contact care activities . 2. Review of the medical record revealed Resident #16 was admitted on [DATE], with diagnoses including Heart Failure, Hypertension, and Pressure Ulcer stage 4. Review of Resident #16's care plan dated 4/5/2024, revealed .Enhanced Barrier precautions as ordered . Approach: Staff to wear PPE as indicated while providing care . Review of Physician's Orders dated 8/12/2024, revealed .Enhanced Barrier Precautions for Indwelling Catheter every shift . Review of the medical record revealed Resident #16's care plan and Physician Order did not reflect Enhanced Barrier Precautions for the stage 4 pressure ulcer to sacrum. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #16's Brief Interview for Mental Status (BIMS) was coded as 15 indicating cognition was intact. Resident #16 was coded for an unhealed stage 4 pressure ulcer prior to admission and required maximal assistance of staff for activities of daily living (ADLs). (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 Physician's Orders dated 2/13/2024, revealed .Cleanse stage 4 pressure injury to sacrum with Vashe irrigation [a topical solution that contains hypochlorous acid [HOCl], a naturally occurring molecule produced by the immune system to fight infection], apply skin prep [skin protectant] to intact skin, cut and size Aquacel Extra [wound dressing composed of 2 layers of Hydro fiber [used for managing a wide range of moderate to highly exuding [discharge of moisture or a smell] wounds, cover with Aquacel Foam [absorbent foam pad] or sacral dressing. Change once a day Mon, [Monday], Wed [Wednesday], Fri [Friday] .and PRN [as needed] for saturation or dislodgement . Observation in Resident #16's room on 2/13/2025 at 10:50 AM, revealed LPN (Licensed Practical Nurse) I and NA (nursing assistant) H did not wear or don PPE during wound assessment of stage 4 sacral pressure ulcer. NA H turned and repositioned Resident #16 onto her right side with gloved hands, not wearing a PPE gown as Resident #16's moist stained top sheet and stained incontinent pad touched the uniform of NA H, while holding the resident on her right side. LPN I with a gloved hand and no PPE gown was kneeling on the resident's left side of bed, knelt beside bed with her uniform and right elbow touching Resident #16's dirty linen and fitted bed sheet. LPN I with gloved hands, touched wound area, moving and raising Resident #16's left buttock up revealing the stage 4 wound with a flashlight. LPN I removed the wrinkled displaced dirty bandage from the sacral wound. LPN I lifted Resident #16's left buttock to expose the moist stage 4 pressure ulcer, revealing blood-tinged exudate drainage from the wound bed without wearing appropriate PPE for enhanced barriers. NA H and LPN I did not use appropriate PPE before, or during wound assessment, and while touching Resident #16's sacral area and bed linens. During an interview on 2/13/2025 at 11:05 AM, LPN I was asked if she should wear a PPE gown when exposing and touching a resident's open wound for Enhanced Barrier Precautions. LPN I stated, .Yes . During an interview on 2/13/2025 at 11:35 AM, NA H was asked should a PPE gown be worn when turning and repositioning a resident with an open wound during wound assessment. NA H stated, yes, especially since the linens may be soiled or wet . During an interview on 2/13/2025 at 2:45 PM, the MDS Coordinator was asked if Resident #16's care plan and Physician Orders should reflect EBP for the stage 4 pressure ulcer to the sacrum. The MDS Coordinator stated, Yes . The MDS Coordinator was asked when staff should wear PPE for EBP. The MDS Coordinator stated, .gowns and gloves for pegs, catheters, wounds and open areas of any resident . During an interview on 2/14/2025 at 10:11 AM, the Director of Nursing (DON) was asked if EBP included wearing a PPE gown when a resident has an open wound and should staff wear a gown during turning, repositioning and touching the resident's wound area. The DON stated, Yes. The DON confirmed Resident #16's care plan and Physician Orders should reflect EBP for the stage 4 pressure ulcer to the sacrum.