STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445088	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Springfield	608 8th Ave East Springfield, TN 37172

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation and interview, the facility failed to protect the residents' right to be free from sexual abuse by another resident for 3 of 6 (Resident #1, Resident #6, and Resident #9) sampled residents reviewed for abuse. At an unknown date and time between [DATE] - [DATE], Resident #1 who was severely cognitively impaired was sexually assaulted by Resident #6. Resident #6 who was moderately cognitively impaired was found naked from the waist down and had climbed into his roommate's bed (Resident #1) and attempted sexual intercourse. Certified Nursing Assistant (CNA) C observed that the lights were off, the curtain was pulled between A and B bed, and Resident #6 was on top of Resident #1 (B bed). CNA C screamed for assistance. Licensed Practical Nurse (LPN) A and CNA K arrived to assist CNA C. It took the 3 staff members to remove Resident #6 off Resident #1. Resident #6 remained in the facility without any documented supervision until his discharge on [DATE] at 11:03 AM. On [DATE], Resident #9, who had a BIMS of 15, reported to Family Member (FM) O while she was visiting the facility, that Visitor P had touched her inappropriately. Resident #9 reported Visitor P leaned in for a kiss and grabbed her breast. Resident #9 reported Visitor P had touched her inappropriately every Monday, Wednesday, and Friday during bingo activity. FM O contacted a family friend (Named Lieutenant #1) who contacted Visitor P, who admitted to touching and sexually assaulting Resident #9. Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified related to the facility's failure to perform a thorough investigation related to Resident #1's sexual abuse, placed all residents at risk. The facility's failure to adequately supervise and manage Resident #6's sexual behaviors put Resident #1 and other vulnerable residents at risk for serious harm, serious injury, serious impairment, or death. The facility's failure to protect Resident #9 from sexual abuse resulted in sadness and anxiety. The facility's failure to recognize and evaluate Visitor P's continued visits and inappropriate touching placed all residents at risk for serious harm, serious impairment, or death. The Regional Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy for F-600 on [DATE] at 2:48 PM, in the Conference room. The facility was cited at F-600 at a scope and severity of J, which constitutes Substandard Quality of Care. A partial extended survey was conducted from [DATE] through [DATE]. An acceptable Removal Plan, which removes the immediacy of the Jeopardy for F-600 was received on [DATE]. The Removal Plan was validated onsite by the surveyor on [DATE] through audit review, medical record review, observation, review of education records, and staff interviews. The IJ began on [DATE] and was removed on [DATE]. The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Patient Protection and Response Policy for Allegation/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated [DATE], revealed .Abuse.will not be tolerated by anyone, including staff, patients.friends, visitors or any other individual in this center. The patient has the right to be free from abuse.Abuse.the willful infliction of injury, unreasonable confinement, intimidation.Sexual Abuse.non-consensual sexual contact of any type with a patient that includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.The center [facility] will provide supervision and support services designed to reduce the likelihood of abusive behaviors.All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors.The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any center partner.The center will not retaliate against any partner who makes a report.Patients with needs and behaviors that might lead to conflict with partners or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict. Identification of patients whose personal histories render them at risk for abusing other patients or partners. Assessment of appropriate intervention strategies to prevent occurrences.Any patient event that is reported to any partner by patient, family, other partner or any other person will be considered an allegation of.abuse. Any complaint of sexual harassment, sexual coercion, sexual assault, or inappropriate touching.Any partner having either direct or indirect knowledge of any event that might constitute abuse.must report the event immediately not later than 2 hours after forming the suspicion if the events that cause the suspicion involve

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to ensure alleged violations involving abuse were reported immediately, but not later than 2 hours, after the allegation was made for 2 of 6 (Resident #1 and Resident #6) sampled residents reviewed for abuse. The findings include: 1. Review of the facility policy titled, Patient Protection and Response Policy for Allegation/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation dated 2/1/2023, revealed .Abuse.will not be tolerated by anyone, including staff, patients.The patient has the right to be free from abuse.Abuse.the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm.Sexual Abuse.non-consensual sexual contact of any type with a patient that includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors.All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors.The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any center partner.The center will not retaliate against any partner who makes a report.intervention strategies to prevent occurrences.Any patient event that is reported to any partner by patient.other partner or any other person will be considered an allegation of.abuse.Any complaint of sexual harassment, sexual coercion, sexual assault, or inappropriate touching.Any partner having either direct or indirect knowledge of any event that might constitute abuse.must report the event immediately.not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse.It is the policy of this facility that abuse allegation.are reported per Federal and State Law. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Dementia, Delirium, Paroxysmal Atrial Fibrillation, Blindness (left eye), and Adult Failure to Thrive. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had severe visual impairment, and poor short term and long-term memory. Resident #1 required substantial/maximal assistance with toileting, shower/bathing, dressing, and bed mobility. 3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included Diabetes Mellitus, Dementia, Traumatic Brain Injury (TBI), and Schizoaffective Disorder. Review of the quarterly MDS dated [DATE], revealed Resident #6 had a BIMS score of 9 which indicated moderate cognitive impairment. Resident #6 had physical behaviors toward others for 1-3 days during the assessment period. Resident #6 required supervision with dressing, toileting, personal hygiene and could walk independently 50 feet with two turns. Review of a typed statement completed by the Administrator dated 9/17/2024, revealed .DOSS [Director of Social Services] and Administrator were called on the night of 9/17/24 [2024] in regards to [Named Resident #6] on top of [Named Resident #1]. DOSS and Admin arrived to center after patients had been separated. Upon interviews with staff [Named Resident #1] remained asleep in bed during the entire event. [Named Resident #1] was fully clothed and had blankets on top of him. [Named Resident #6] had attempted to climb in bed with [Named Resident #1] and did not want to exit the bed, requiring multiple staff members to assist him. [Named Resident #1] was assessed and had no injuries. [Named Resident #6] was escorted to the dining room where he was notably confused. When questioned by Administrator he stated that he had not seen his roommate for several hours today and had been on the porch for most of the day. Room change was provided for [Named Resident #1] and an inpatient psych referral was sent for [Named Resident #6] . Review of an undated written statement completed by CNA C revealed, .I put [Named Resident #1] in bed cause [because] He was ready to lay down. I went to check on him to make sure he was still in bed. I knock on the door and find [Named Resident #6] on top of him. I asked him to get down off of him and he refused to get down off of him. I stay by the door hollering for the nurse to come down to the room to help to get [Named Resident #6] off of his roommate . During a telephone interview on 9/8/2025 at 12:21 PM, LPN A stated, .I was called by a tech [CNA C].the CNA was in shock.she kept saying come, come.I ran to her.I saw [Resident #6] on top of him [Resident #1] humping him, he [Resident #6] was naked from waist down, I turned the light on, I was saying get off of him.he was fighting us.he elbowed me.all the nurses in the building came to help me. During an interview on 9/9/2025 at 12:42 PM, the DOSS was asked as the Abuse Coordinator what would he want to make sure happened with (Named Resident #1). The DOSS stated , make sure his psychosocial needs were met . The DOSS

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy, medical record review, facility investigation review, and interviews, the facility failed to complete a thorough investigation and report the results of all investigations to the State Survey Agency, within 5 working days of the incident for 2 of 6 (Resident #1 and Resident #60) residents reviewed for abuse. The findings include: 1. Review of the facility policy titled, Patient Protection and Response Policy for Allegation/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated 2/1/2023 revealed, .Abuse.will not be tolerated by anyone.The patient has the right to be free from abuse.Abuse.the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm. Sexual Abuse.non-consensual sexual contact of any type with a patient that includes but is not limited to, sexual harassment, sexual coercion, or sexual assault.The center will provide supervision and support services designed to reduce the likelihood of abusive behaviors.All supervisory partners who receive reports of and/or identify inappropriate behaviors will take immediate steps to correct such behaviors.The right to report a concern or incident is not limited to a formal, written grievance process but includes any verbalized complaint to any center partner.Patients with needs and behaviors that might lead to conflict with partners or other patients will be identified by the Care Planning team, with interventions and follow through designed to minimize the risk of conflict.Assessment of appropriate intervention strategies to prevent occurrences.Any patient event that is reported to any partner by patient, family, other partner or any other person will be considered an allegation of either abuse.Any complaint of sexual harassment, sexual coercion, sexual assault, or inappropriate touching.Any partner having either direct or indirect knowledge of any event that might constitute abuse.must report the event immediately.not later than 2 hours after forming the suspicion if the events that cause the suspicion involve abuse.It is the policy of this facility that abuse allegation.are reported per Federal and State Law.The Administrator or Director of Nurses will determine the direction of the investigation once notified of alleged incident.The investigation is conducted immediately under the following circumstances.When it is identified that an alleged incident may have occurred.As soon as any partner has knowledge and reports an alleged event.When there is a question as to whether to conduct an investigation, it is best to do so.The results of all investigations will be completed within five working days of the incident. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Dementia, Delirium, Paroxysmal Atrial Fibrillation, Blindness (left eye), and Adult Failure to Thrive. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had severe visual impairment, poor short term and long-term memory. Resident #1 required substantial/maximal assistance with toileting, shower/bathing, dressing, and bed mobility. 3. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses which included Diabetes Mellitus, Dementia, Traumatic Brain Injury (TBI), and Schizoaffective Disorder. Review of the quarterly MDS dated [DATE] revealed Resident #6 had a BIMS score of 9 which indicated moderate cognitive impairment. Resident #6 had physical behaviors toward others for 1-3 days during the assessment period. Resident #6 required supervision with dressing, toileting, personal hygiene and could walk independently 50 feet with two turns. Review of a typed statement completed by the Administrator dated 9/17/2024, revealed the Administrator and Director of Social Services (DOSS) were notified the night of 9/17/2024 that Resident #6 was on top of Resident #1. The Administrator and DOSS came to the facility after the residents were separated.Upon interviews with staff [Named Resident #1] remained asleep in bed during the entire event .was fully clothed and had blankets on top of him. [Named Resident #6 had attempted to climb in bed with [Named Resident #1] and did not want to exit the bed, requiring multiple staff members to assist him. [Named Resident #1] was assessed and had no injuries. [Named Resident #6] was escorted to the dining room where he was notably confused. When questioned by Administrator he stated that he had not seen his roommate for several hours today and had been on the porch for most of the day. Room change was provided for [Named Resident #1] and an inpatient psych referral was sent for [Named Resident #6] . 4. Review of the facility investigation dated 9/17/2024, revealed the following: a. A typed statement completed by the Administrator (not present during the allegation of sexual abuse) dated 9/17/2024. The Administrator's typed statement referred to interviews with staff that revealed [Named Resident #6] got into bed with his roommate and did not want to exit the bed. No time was noted in the typed statement. The facility investigation included only one written statement from

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F 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Facility Assessment review, employee file review, medical record review, observation, and interview, the facility failed to ensure all nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely for 1 of 10 (Resident #11) sampled residents. On 1/21/2025, Resident #11 was found in the floor of her room laying face down with her right lower extremity (RLE) next to her face and her left upper extremity (LUE) under her abdomen. Resident #11 was crying and moaning in pain. Licensed Practical Nurse (LPN) L documented that she gently repositioned Resident #11's RLE to baseline, which resulted in actual Harm to Resident #11. Resident #11 was transferred to the hospital where radiology revealed a right distal femur fracture with posterior displacement (broken thighbone just above the knee, with the broken part of the bone shifted backward). The findings Include: 1. Review of the Facility Assessment with a revision date 1/20/2025, revealed .Center resources needed including, but not limited to, providing competent care for patients. 2. Review of the employee file for LPN L revealed, .Job Description Acknowledgement.5/14/2024.Is responsible for maintaining clinical competency as evidenced by application of integrated nursing knowledge and skills.Integrates current standards of practice.related to nursing services in the care of patients.Hire as of 05/24/2024.Competency Checklist.5/21/2025.Falls Management Process. 3. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE], with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction, Dysphagia, and Hypertension. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #10 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated no cognitive impairment. 4. Review of the medical record revealed Resident #11 admitted to the facility on [DATE], with diagnoses which included Dementia, History of falling, and Essential Hypertension. Review of the quarterly MDS dated [DATE], revealed Resident #11 had a BIMS score of 4, which indicated severe cognitive impairment. Resident #11 was dependent for toileting and lower body dressing and required substantial/maximal assistance with bathing and transfers. Review of the Progress Notes dated 1/21/2025 at 12:29 PM, revealed .Resident [Resident #11] found on floor in her room. Notified by another resident.he [Resident #10].immediately notified this nurse at 1215 [12:15 PM]. Resident assessed on floor. Resident found on floor laying face down with RLE next to face and LUE under abdomen. Resident crying and moaning in pain. Unable to assess skin from waist down d/t [due to] pain.supervisor notified. 911 called for resident to be transported.EMS [Emergency Management Services] on site stabilized resident and managed pain before transport.Edited by [Named LPN S] on 1/21/2025 at 01:22 PM. Review of the Progress Notes dated 1/21/2025 at 12:20 PM, revealed .Recorded as Late Entry on 01/21/2025 at 03:43 PM.Assessed patient post unwitnessed fall. Patient found on floor laying face down, LUE under and behind upper body and RLE bent inward with heel pointing toward head, crying out in pain and grimacing. Patient's upper trunk was lifted just enough to return LUE to resting position. RLE was gently repositioned, moving at patient's tolerance level until angle of RLE returned to baseline. Patient stated that pain to knee was significantly relieved but still extremely tender. Pain to upper R [right] thigh continues. Patient remains in recovery position on L [left] side for safety. MD [Medical Doctor] notified, floor nurse to activate EMS. The Progress Note was completed by LPN L/Unit Manager. Review of EMS #1's run report dated 1/21/2025, revealed . [Named Resident #11].Injury of Thigh (Upper Leg).Patient's Level of Distress Severe.Fall on same level - 2 ft [feet]-Nursing home.12:38 [PM].IV [intravenous] Therapy.12:40 [PM] Ketamine [medication that temporarily blocks pain and other sensations, allowing medical procedures to be performed comfortably] 15 Milligrams (mg) IV.Patient Response: Unchanged.12:50 [PM] Ketamine 15.mg.IV.Patient Response Improved.13:20 [2:20 PM] Zofran [medication given for nausea] 4.mg.IV.13:22 [1:22 PM] Fentanyl [opioid drug given for pain] 50 Micrograms (mcg).IV.Patient Response: Improved.13:32 [1:32 PM] Fentanyl 50.mcg.IV.Patient Response: improved.13:40 [1:40 PM] Trauma Alert.Pt [patient] is found lying on.floor of her room, in obvious pain. Pt had suffered a fall from wheelchair.Pt has what appears to be a deformity to the right distal femur. Due to pt's amount of pain, the decision to give pain medication prior to moving was decided. Pt was placed in a cervical collar due to cervical spine pain upon palpation as well as ROM [range of motion].Pt would not tolerated [tolerate] attempting to splint the leg. Pt was taken to med [ambulance] unit.During transport, pt became tearful, and appeared and displayed increased pain. 4 mg Zofran administered, followed by 50 mcg Fentanyl, after approximately 5 minutes, additional 50 mcg Fentanyl was administered. Pt then became