STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445094	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Lewisburg	1653 Mooresville Highway 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, record review, and facility policy review, the facility failed to ensure nursing staff did not pre-pour and store medications in advance of medication administration for 10 (Residents #47, #1, #39, #15, #23, #8, #56, #67, #59 and #17) of 24 residents who received medications from the 200 Hall medication cart. The findings include: A facility policy titled, Medication Storage in the Facility, revised 02/25/2025, revealed, C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. A facility policy titled, Medication Administration - General Guidelines, revised 02/25/2025, revealed the section titled, B. Administration, included, 4. When medications are administered by mobile cart taken to the resident's location (room, dining area, etc. [et cetera, and so forth]) medications are administered at the time they are prepared. Medications are not pre-poured either in advance of the med [medication] pass or for more than one resident at a time. 5. In no case shall more than one dose time be prepared in advance. Further review revealed, 21. The resident is always observed after the administration to ensure that the dose was completely ingested. If only a partial dose is ingested, this is noted on the MAR [medication administration record], and action is taken as appropriate. During an observation on 2/23/2026 at 11:22 AM, Licensed Practical Nurse (LPN) #3 was scanning medications, opening medication packaging, and pouring loose pills into a transparent plastic cup. LPN #3 then wrote a resident's name on the cup with a marker and placed the cup back into the medication cart drawer. An observation of the medication cart revealed multiple cups containing loose, unlabeled medications, including: 11 loose pills for Resident #47, eight loose pills for Resident #15, 10 loose pills for Resident #23, one loose pill for Resident #8, two loose pills for Resident #56, six loose pills for Resident #67, five loose pills for Resident #17, and nine loose pills for Resident #59. On 2/23/2026 at 11:43 AM, LPN #3 stated that she pre-poured medications, placed them into medication cups, wrote the residents' names on the cups, stored the cups in the medication cart, and administered the medications when the residents became available. LPN #3 reported that she was not sure if that was good practice to prepare mediation ahead of administration but stated she felt confident in her ability to do so. When asked if she could identify any of the loose pills once they were removed from their original packaging, LPN #3 stated she could not identify them once removed. On 2/23/2026 at 11:36 AM, LPN #3 stated she was working on two residents at the same time, specifically Resident #1 and Resident #39. During a concurrent observation, three small medication cups were observed, each containing two pills, along with one fluid cup containing a cloudy liquid. LPN #3 continued to pull medications for both residents simultaneously, switching between screens during the process. LPN #3 stated she was not concerned about making mistakes or becoming confused because she knew the residents on the 200 Hall well. On 2/24/2026 at 6:53 AM, LPN #2 stated it was never acceptable to pre-pull medications and that doing so was against nursing standards because it increased the risk of medication errors. She stated that once pills were removed from their original packaging, it became impossible to identify them. LPN #2 further stated that working consecutively on two residents could place residents at risk if the nurse became distracted or confused, describing the practice as an accident waiting to happen. On 2/24/2026 at 7:59 AM, Registered Nurse (RN) #1 stated that keeping loose pills in the medication cart or preparing medications simultaneously for more than one resident (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should never occur because medications could be easily mixed up and a mistake could be made. On 2/25/2026 at 2:05 PM, the Director of Nursing (DON) stated that nurses were expected to follow facility guidance and accepted standards for medication administration. She stated that medications must remain intact in their original pharmacy packaging or in individually wrapped packets with the resident's identifying information until the moment of administration. The DON stated that working on more than one resident's medications at a time could result in medication errors. She further stated her expectation was that nurses follow facility policy and adhere to good and safe nursing practices. On 2/26/2026 at 9:46 AM, the Administrator (ADM) stated that the pharmacy delivered medications daily, and medications arrived individually wrapped, which were scanned and then dispensed. The ADM stated having loose pills in the medication cart and preparing medications for two residents simultaneously was unacceptable and not consistent with facility protocol. The ADM stated that the expectation was for nurses to follow the facility policy and good standards of practice.

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, record review, and facility policy review, the facility failed to ensure a resident that was self-administering medications was assessed for the capability to self-administer medications for 1 (Resident #53) of 2 residents reviewed for medication administration. The findings include: A facility policy titled, Self-Administration of Medication, revised 02/25/2025, revealed, IN order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. The policy revealed, If the resident desires to self-administer medications, a physician order should be obtained then an assessment is conducted by a member of the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility. For those residents who self-administer, a member of the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or if needed, when there is a significant change in condition. The results of the interdisciplinary team members' assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted. A Resident Face Sheet indicated the facility admitted Resident #53 on 04/12/2021. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of hypertensive heart disease with heart failure, major depressive disorder, and chronic atrial fibrillation. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/28/2026, revealed Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #53's Orders revealed the resident had physician orders for the following oral medications scheduled to be administered at 8:00 A.M.: allopurinol (medication to treat gout) 50 milligrams (mg), Bystolic (medication to treat high blood pressure) 5 mg with instructions that indicated the resident's pulse and blood pressure were to be obtained prior to administration, Cardizem (medication to treat high blood pressure) 120 mg, Eliquis (a blood thinner) 2.5 mg, famotidine (medication to reduce stomach acid) 20 mg, potassium chloride (medication to treat low potassium and maintain fluid and electrolyte balance) 10 milliequivalents (mEq), gabapentin (medication to treat nerve pain) 100 mg, Lasix (medication to treat fluid retention) 40 mg, loratadine (medication to treat allergies) 10 mg, and vitamin D3 50 micrograms (mcg). Further review revealed no physician order authorizing the resident to self-administer medications or permitting the resident's medications to be kept at the bedside. During an observation on 2/23/2026 at 9:32 AM, a medication cup labeled with Resident #53's name was observed at the resident's bedside containing seven loose pills. During a concurrent interview, Resident #53 stated the nurse had left the medication cup for them to self-administer, and that they preferred it that way. Resident #53's Care Plan Report did not reveal a care plan for self-administration of medication. Resident #53's assessments did not reveal a self-administration of medication assessment. On 2/23/2026 at 9:36 AM, Licensed Practical Nurse (LPN) #3 stated she had left the medication cup containing pills at Resident #53's bedside because the resident was alert, able, and preferred the pills to be left at the bedside. LPN #3 further stated the resident had not been assessed to determine whether they were able to safely self-administer medications, and there were no physician orders authorizing medications to be left at the bedside. On 2/24/2026 at 6:53 AM, LPN #2 stated that medications may be left at the resident's bedside only if the resident had been assessed and determined safe to self-administer. LPN #2 further stated that if a resident requested medications to be left at the bedside, or if staff were aware that a resident preferred medications in that manner, an assessment should have been completed rather than leaving the medications at the bedside without an assessment. On 02/24/2026 at 7:59 AM, Registered Nurse (RN) #1 stated that Resident #53 was alert (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and able to take their medications if they were left at the bedside. However, RN #1 further stated that an assessment, a physician's order, and a care plan would be required prior to permitting medications to be left at the bedside for a resident to self-administer. On 02/25/2026 at 1:17 PM, the Director of Nursing (DON) stated the facility had a self-administration medication policy for residents who wished to self-administer their medications. The DON stated that Resident #53 did not have a self-administration assessment completed, nor was there a physician's order authorizing the resident to self-administer medications. The DON further stated the facility's expectation was that nurses would follow facility policy regarding resident safety. On 02/26/2026 at 9:43 AM, the Administrator (ADM) stated that Resident #53 had requested that the nurse leave their medications at the bedside, and the nurse had complied with the resident's request without following the facility's self-administration policy. The ADM further stated the expectation was for the facility's nurses to follow the facility's policy regarding self-administration of medications.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview, record review, and review of the Resident Assessment Instrument (RAI) Manual guidelines, the facility failed to accurately complete the Minimum Data Set (MDS) assessments for 2 (Resident #7 and Resident #50) of 2 residents reviewed for MDS discrepancies. The findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, indicated, Those residents covered by Level II PASRR [Pre-Admissions Screening and Resident Review] process may requires certain care and services provided by the nursing home, and/or specialized services provided by the state. The RAI manual further indicated section A1500 should be coded yes if PASRR Level II screening determined that the resident has a serious mental illness and/or ID [intellectual disability]/DD [developmental disability] or related condition. 1. A Resident Face Sheet revealed the facility admitted Resident #7 on 06/01/2022. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of spina bifida with hydrocephalus, bipolar disorder, panic disorder, borderline personality disorder, and post-traumatic stress disorder. Resident #7's Notice of PASRR Level II Outcome Nursing Home Approval, dated 06/14/2022, indicated Resident #7 had a Level II PASRR evaluation and the Department of Mental Health and Substance Abuse Services and Department of intellectual and Developmental Disabilities decided that you need special services for your mental health, intellectual disabilities, or related condition. These special services can be provided while you are in the nursing home. An admission MDS, with an Assessment Reference Date (ARD) of 12/03/2025, indicated Resident #7 was not currently considered by the state Level II PASRR process of having a serious mental illness and/or intellectual disability or a related condition. During an interview on 02/25/2026 at 2:56 PM, the Director of Social Services (DSS) stated that Resident #7 had a positive Level II PASRR. The DSS stated the MDS Coordinator was responsible for coding the PASRR status on the MDS assessment. During an interview on 02/25/2026 at 3:00 PM, the MDS Coordinator stated a Level II PASRR should be coded on the MDS assessment. The MDS Coordinator confirmed that Resident #7 had a positive Level II PASRR, and it should have been coded on the MDS assessment. During an interview on 02/25/2026 at 3:12 PM, the Director of Nursing (DON) stated that she expected the MDS to be coded correctly for all sections. The DON stated the facility did not have a policy for MDS assessments, but they followed the RAI manual. During an interview on 02/26/2026 at 8:33 AM, the Administrator (ADM) stated he expected the MDS assessments to be accurate. The ADM stated if a resident had a Level II PASRR, staff should code it correctly on the MDS assessment. 2. A Resident Face Sheet revealed the facility admitted Resident #50 on 01/20/2023. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of bipolar disorder. Resident #50's Notice of PASRR Level II Outcome Nursing Home Approval, dated 02/16/2023, indicated Resident #50 had a Level II PASRR evaluation and the Department of Mental Health and Substance Abuse Services decided that you need special services for your mental health, intellectual disabilities, or related condition. These special services can be provided while you are in the nursing home. An annual MDS assessment, with an Assessment Reference Date (ARD) of 11/24/2025, indicated Resident #50 was not currently considered by the state Level II PASRR process of having a serious mental illness and/or intellectual disability or a related condition. During an interview on 02/25/2026 at 2:56 PM, the Director of Social Services (DSS) stated that Resident #50 had a positive Level II PASRR. The DSS stated the MDS Coordinator was responsible for coding the PASRR status on the MDS assessment. During an interview on 02/25/2026 at 3:00 PM, the MDS Coordinator stated a Level II PASRR should be coded on the MDS assessment. The MDS Coordinator confirmed that Resident #50 had a positive Level II PASRR, and it should have been coded on the MDS assessment. During an interview on 02/25/2026 at 3:12 PM, the Director of Nursing (DON) stated that she expected the MDS to be coded correctly for all sections. The DON stated the facility did not have a policy for MDS assessments, but they followed the RAI manual. During an interview on 02/26/2026 at 8:33 AM, (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Administrator (ADM) stated he expected the MDS assessments to be accurate. The ADM stated if a resident had a Level II PASRR, staff should code it correctly on the MDS assessment