STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445108	A. Building B. Wing	08/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Murfreesboro	420 N University St Murfreesboro, TN 37130

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, observation, and interview, the facility failed to provide an environment free from physical restraints for 1 (Resident #3) of 3 sampled residents reviewed for restraints. The findings include: Review of the facility policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated [DATE], revealed, .Abuse, Neglect .will not be tolerated by anyone, including staff .family members or legal guardians .The patient has the right to be free from abuse .This includes but is not limit to freedom from .any physical restraint .not required to treat the patients medical symptoms .All allegations of possible abuse .will be immediately assessed to determine the appropriate direction of the investigation . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Local infection of the skin and subcutaneous tissue, Acute Respiratory Failure with Hypoxia, Metabolic Encephalopathy, Muscle Wasting and Atrophy, Unspecified Dementia, Contusion of right lower leg, and History of falling. Resident #3 expired at the facility on [DATE]. Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Continued review revealed Resident #3 required extensive assistance of two plus person physical assistance for bed mobility, transfer, toileting, personal hygiene, and limited assistance of one person for dressing. Continued review revealed Resident #3 had limitation in range of motion with both lower extremities. Further review revealed Resident #3 had a fall in the last ,d+[DATE] months. Review of the facility Safety Events (Incident Reports), with dates ranging from ,d+[DATE] through , d+[DATE], revealed Resident #3 had a total of 39 documented falls with various injuries, which included 2 major injuries that required hospital transfer for evaluation. (Refer to Tag F689) During an interview on [DATE] at 5:20 PM, Certified Nursing Assistant (CNA) K stated, .[Named Resident #3] had a lot of falls .when she came back from hospital, she was mainly in the bed .we mainly used a lift with her, and you always need 2 people when you use the lift .her bed was kept against the wall and she had a clip alarm to alert us if she was trying to get up . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445108	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/02/2024
NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, Murfreesboro		STREET ADDRESS, CITY, STATE, ZIP CODE 420 N University St Murfreesboro, TN 37130	

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 1:54 PM, Family Member (FM) O stated, .the facility called me when she [Resident #3] had the fall [DATE] .he [Licensed Practical Nurse LPN I] just said I need you to go to the hospital .she had so many falls since she had been there .the Administrator called me the next day .she couldn't tell me how long she laid in the floor or what time for sure it happened .you know the staff would put chairs against the end of the bed to keep her restrained to the bed .I have pictures of it .we have walked in and the bed be against the wall and two chairs at the end of her bed . Review of the undated picture provided by FM O revealed Resident #3 in the bed with one side of the bed against the wall and two burgundy chairs sitting at the end of the bed below the half side rail. During a telephone interview on [DATE] at 2:00 PM, CNA P stated, .the staff was very aware of her [Resident #3] fall risk .I have found chairs next to her bed to keep her in the bed .I told the staff it's a restraint she could get hurt you can't do that .it was more than one time I found it that way . During a telephone interview on [DATE] at 2:27 PM, an Anonymous Registered Nurse (RN) stated, .I knew about the chairs sitting next to [Named Resident #3]'s bed .the staff said the family was doing it and staging it but the family said the staff was doing it .I have walked into the room when family had not been there and found two burgundy straight back chairs next to the bed and the other side of the bed against the wall .the daughter reported that the second shift was doing it .the Administrator was aware of it .I told the staff you can't do that . The RN was asked was an in-service given to the staff or any education given to the family about restraints. The Anonymous RN stated, No. During an interview on [DATE] at 4:30 PM, the Administrator was asked if she had been made aware of staff or family placing chairs against the side of Resident #3's bed to restrain her in the bed. The Administrator stated, .Not that I know of .you can't leave chairs next to a bed, that is a restraint . The Administrator reviewed the picture provided by FM O and identified the person in the photo was Resident #3 and confirmed the photo had been taken in Resident #3's room. The photo revealed Resident #3 lying in bed with one side of the bed pushed up against the wall and the other side had 2 chairs placed against the opposite side of the bed.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy, record review, and interview, the facility failed to ensure a discharge summary was completed that contained needed information of the residents stay to ensure a safe discharge for 1 of 3 (Resident #4) residents reviewed for discharge. The findings include: Review of the facility policy titled, TRANSFER/DISCHARGE, dated 2/2023 revealed, .A patient may be transferred or discharged to another health care institution or discharged home upon the written order of the attending physician .Sufficient information will be provided to the patient to assure continuity of care, regardless of the destination of the patient or the reason for the transfer .The center will assist in effecting a smooth transition . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], readmitted on [DATE] and discharged on [DATE] with diagnoses which included Dementia, moderate, with anxiety, Obsessive-compulsive disorder, Unspecified Psychosis, Depression, Alcohol Dependence with alcohol-induced persisting Dementia, Anxiety Disorder, and Pseudobulbar affect. Review of the Behavior Analysis Report revealed on 12/17/2022 Resident #4 was wandering hallway and attempting to enter other resident ' s room. Continued review revealed on 12/30/2022 Patient searching nurses' station for drinks/snacks and grabbing multiple supplements, attempted to redirect and pt stated, You can't tell me what to do. On 1/6/2022 resident repeatedly in and out of nurses' station stealing supplements/snacks, hiding items under shirt or in her purse. On 2/17/2023 Resident #4 smeared feces on curtain. Continued review revealed on 3/10/2023 Resident #4 with usual wandering behavior. On 3/13/2023, Resident #4 taking food (pudding) and supplement off med cart and med cart cooler and 3/14/2023 Resident #4 rummaging on top of med cart, cabinets, and cooler. Review of the comprehensive care plan for Resident #4 revealed a problem start date of 4/5/2022 at risk for alteration in behaviors related to diagnoses of Dementia, psychosis, anxiety, as evidenced by restlessness pacing and wandering. Continued review of the comprehensive care plan for Resident #4 revealed she likes to travel around the environment and may occasionally follow others into other rooms/areas and assist her back to common area as needed. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. Continued review revealed Resident #4 had delusional behaviors and wandered daily over the last 7 days. Further review revealed the wandering impact placed the resident at significant risk of getting to a potentially dangerous place and wandering intrudes on the privacy of others. Review of the Behavior Analysis Report revealed on 4/8/2023 resident had been going to other residents' rooms, to nurses' station, trying to steal food and drinks, did not sleep much. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Elopement Risk dated 5/27/2023 for Resident #4 revealed resident exhibited wandering or exit seeking behavior in the last 90 days. Continued review revealed Resident #4 was independently ambulatory. Review of the Quarterly MDS dated [DATE] revealed Resident #4 had a BIMS score of 4 which indicated severe cognitive impairment. Review of the Psychiatric Nurse Practitioner (NP) Progress Notes revealed, .6/9/2023 .PSYCHOTIC SYMPTOMS .Preoccupation with the bathroom/toilet and at times will smear feces due to confusion . Preoccupation with food and continues to take food items from nursing carts/others .Patient denies AH/VH [Auditory Hallucination/Visual Hallucination] but had been observed responding to internal stimuli and talking to self and has been talking to her daughter, when daughter is not present and has made some delusional thinking about someone 'being hit by a train' and that someone 'being molested'. Patient denies these things to writer today .Chronic pacing .Due to severity of cognitive deficits, her behaviors will most likely progress/worsen as her overall condition declines. Redirection or patient education is not effective due to her cognition and inability to recall information .Prognosis is guarded and she may eventually need placement in a memory care unit or a geriatric behavioral nursing facility . Review of the Behavior Analysis Report revealed on 6/16/2023, Resident #4 rummaging through roommate's clothes and trying to take food from tray rack (clean and dirty). Review of the Psychiatric Nurse Practitioner Progress Notes revealed, .7/10/2023 .Chronic pacing and asking for multiple things repetitively due to significant short-term memory impairment .Patient with progressing behaviors and has begun taking peer's clothes and putting soiled linens in peer's bed. She continues to respond to internal stimuli and has been having extended conversations with unseen people. Her hallucinations do not appear to be bothersome or distressing to her, however her behaviors towards her peers have been distressing to them. Will increase Seroquel [antipsychotic medication used to treat psychosis] .Will D/C [discontinue] Depakote [anticonvulsant medication used as a mood stabilizer] since she is taking a low dose .increasing Seroquel for psychosis/disorganization . Further review of the Psychiatric Nurse Practitioner Progress Notes revealed, .7/17/2023 .Chronic pacing in the afternoon/evening and asking for multiple things repetitively due to significant short term memory impairment .No history of inpatient psychiatric hospitalization . Review of the Care Conference Report for Resident #4 dated 7/20/2023 revealed, .Care Plan meeting held today. Present were Social Work, Nurse Manager, Dietician, and participating by telephone was patient's daughter .Care Plan, medications, and diet reviewed. Patient's behavior was discussed and nurse shared that there are memory care units that are designed for patients that wander and might be more helpful to her. Daughter agreed with referral being made . Review of the Progress Notes dated 7/26/2023 revealed, .SW (Social Worker) made referral to several long term care facilities that have Dementia and Memory Care units per daughter .agreement during recent care plan meeting .[Named Facility #2] has accepted .[Named Resident #4] as a patient and daughter is in agreement with her mother being transferred and admitted there. [Named Facility #2] to contact daughter and set up a date and time for admission and will inform SW . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes dated 7/27/2023 revealed, .[Named Facility #2] social worker called and stated they are able to admit [Named Resident #4] today .Van Service has been arranged to transport patient around 3:30 PM today . Review of the Department Notes from (Named Facility #2) dated 7/28/2023 8:26 AM, .Late Entry 7/27/23 [2023] .Resident up in the common area asking staff that walked by how to get out of here. Resident is also asking other residents how to get out of here. Unable to redirect. Snack offered and provided. Resident stated in a raised angry tone, 'I did not ask for a snack, if I want a snack I will get one myself' . Continued review of the Department Notes dated 7/28/2023 11:59 AM, .spoke with daughter, with daughter stating she thought her mom was going to a nursing home with a memory care unit .daughter did not realize facility does not have a memory care unit .daughter plans to come in on this date, will have further discussion of resident plan of care at that time . Continued review of the Department Notes dated 7/28/2023 3:33 PM revealed, . spoke with .daughter at bedside to review residents behaviors, resident has behaviors prior to admission to this facility .adjusted psychotropic medication in facility multiply [multiple] times stated by daughter .reviewed in patient psych stay at behavioral unit may benefit resident, daughter agreeable .4:07 PM New order received to initiate transfer .for eval and treat for possible inpatient psych stay, EMS [Emergency Management Service] notified of need for transport . Further review of the Department Notes from (Named Facility #2) dated 8/16/2023 revealed, .Late entry on 8/15/23 [2023] [Named Facility #3] called to inform this writer that they would accept resident as long term for memory care. Daughter contacted via phone to make aware that facility .has accepted resident for long term care. Daughter agreeable with facility to set up transportation . Review of the Transitions of Care/Discharge Summary dated 7/29/2024 (completed by Facility #1- 2 days after Resident #4's discharge) revealed, .Mood and Behavior Patterns .other behavioral symptoms directed toward others .Behavior of this type occurred 1 to 3 days .Care Plan Goals .Goal Date .9/15/2023 Will have elopement risk minimized through next 120 days or next review. Will remain in safe confines of center unless supervised by staff/representative . The completion date of the discharge summary revealed it was completed after her discharge and could not have been sent or faxed to [Named Facility #2] on the day of discharge 7/27/2024. During an interview on 7/29/2024 at 4:10 PM, Social Service Director (SSD) stated, .We were wanting to find safer placement for [Named Resident #4] .she was needing more of a secured unit .dementia unit .she was on the 2nd floor but she was exit seeking .flushing clothing and food down the toilet .daughter was aware of her transfer to [Named Facility #2] .a discharge summary would have been sent . During a telephone interview on 7/29/2024 at 7:38 PM, The Complainant stated, .I was told it would be more beneficial for [Named Resident #4] to transfer to another facility with memory care .they didn't give me a definite date at that point .On 7/27/2023 I was told I needed to go to the new facility [Facility #2] and sign papers .I explained to them I couldn't go until 7/28/2023 because I was out of town. The new facility [Named Facility #2] called me and said mom was already there .[Named Facility #1] had mom to wear an ankle monitor and had a secured door but the facility they sent her to does not have ankle monitors and no secured doors .[Named Facility #1] transferred mom to where she was a flight risk . (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/2024 at 10:15 AM, Social Worker H stated, .[Named Resident #4] needed a specialized dementia unit .the daughter was aware of the discharge and I faxed out the referral to [Named Facility #2] .the Admission Coordinator at the facility is the one that accepted her transfer . During a telephone interview on 8/1/2024 at 10:25 AM, the Director of Nursing (DON for Named Facility #2) stated, .[Named Resident #4] is no longer at our facility .she is now at a memory care unit at [Named Facility #3] .our doors can be pushed on and after a few seconds they will open we are not a locked unit .when she got here she was confused, wandering, pushing on exit doors, cursing, threatening behaviors .we had to place her on 1 on 1 supervision .We sent her out for a psychiatric stay and she came back but she was still exit seeking .I sent out further referrals and found a locked facility for her .the daughter understood from the previous facility [Named Resident #4] wound be transferring to a secured unit .it was not a safe transfer .it was not in her referral that she was exit seeking and that is not what we understood when she was being transferred to our facility .we do not have a wanderguard system . The DON was asked to email this surveyor a copy of the referral the facility received from (Named Facility #1) on (Named Resident #4). Review of the referral received by Facility #2 revealed Resident #4's wandering and intrusive behavior and risk for elopement was not documented on the Nursing Summary referral. No discharge summary was provided to Facility #2. During an interview on 8/1/2024 at 12:08 PM, the NP stated, .[Named Resident #4] wandered and was exit seeking, very ambulatory .a secured unit would have been better for her . During an interview on 8/1/2024 at 1:00 PM the Administrator was asked if the facility kept a copy of the referral that was sent out on (Named Resident #4). The Administrator stated, .We don't keep a copy of the referrals we send out . During an interview on 8/1/2024 at 3:25 PM, SW H stated, .I saw [Named Resident #4] get on elevator behind some visitors .I was not aware the facility [Named Facility #2] did not have locked doors .I was not aware the facility did not have a wanderguard [ankle monitoring] system . SW H was asked if he had any email correspondence with the Admission Coordinator at [Named Facility #2] he stated, we only talked by phone about [Named Resident #4]. During an interview on 8/1/2024 at 4:07 PM, the Administrator stated, .She [Named Resident #4] was always on the 2nd floor .she never got on the elevator .It was my understanding that [Named Facility #2] had a secured unit . The Administrator was asked does she feel Resident #4 had a safe transfer considering the facility did not have a secured unit. The Administrator stated, .I still feel it would be better for her . During an interview on 8/2/2023 at 8:40 AM, the Medical Director (MD) stated, .[Named Resident #4] was transferred to another facility where I make visits also [Named Facility #3] . The MD was asked why Resident #4 had to be transferred to (Named Facility #3). MD stated, .she needed to be in a locked memory unit the previous settings were not appropriate for her needs .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, facility documentation, and interview, the facility failed to develop and implement a comprehensive, person-centered care plan that addressed discharge plans for 1 (Resident #4) of 3 sampled residents reviewed for discharge. The findings include: Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Dementia, Obsessive-compulsive disorder, Unspecified Psychosis, Depression, Alcohol Dependence with alcohol-induced persisting Dementia, Anxiety Disorder, and Pseudobulbar affect. Resident #4 was discharged on [DATE]. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated severe cognitive impairment. Review of Resident #4's Comprehensive Care Plan, with revision date 5/31/2023, revealed no discharge plan. Review of the Psychiatric Nurse Practitioner (NP) Progress Notes for Resident #4, revealed, .6/9/2023 . Chronic pacing .Due to severity of cognitive deficits, her behaviors will most likely progress/worsen as her overall condition declines. Redirection or patient education is not effective due to her cognition and inability to recall information .Prognosis is guarded and she may eventually need placement in a memory care unit or a geriatric behavioral nursing facility . Review of the Care Conference Report for Resident #4, dated 7/20/2023, revealed, .Care Plan meeting held today. Present were Social Work, Nurse Manager, Dietician, and participating by telephone was patient's daughter .Patient's behavior was discussed and nurse shared that there are memory care units that are designed for patients that wander and might be more helpful to her. Daughter agreed with referral being made . Review of the Progress Notes for Resident #4, dated 7/26/2023, revealed, .SW (Social Worker) made referral to several long term care facilities that have Dementia and Memory Care units per daughter . agreement during recent care plan meeting .[Named Facility #2] has accepted .[Named Resident #4] as a patient and daughter is in agreement with her mother being transferred and admitted there. [Named Facility #2] to contact daughter and set up a date and time for admission and will inform SW . Review of the Progress Notes for Resident #4, dated 7/27/2023, revealed, .[Named Facility #2] social worker called and stated they are able to admit [Named Resident #4] today .Care Ride Van Service has been arranged to transport patient around 3:30 PM today . During an interview on 8/1/2024 at 3:25 PM, Social Worker H was asked to review [Named Resident #4]'s care plan to see if a discharge plan was noted in her care plan. SW H stated, .I don't see one . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/1/2024 at 4:07 PM, the Administrator was asked to review [Named Resident #4]'s care plan for a discharge plan. The Administrator stated, .I don't see a discharge care plan on her .

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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 the facility policy review, medical record review, hospital record review, facility documentation, review of photographs, and interview, the facility failed to provide adequate supervision to prevent accidents for 1 of 3 sampled residents (Resident #3) reviewed for accidents. The findings include: Review of the facility policy titled .Incident and Accident Process . dated 1/2024 revealed, .An incident or accident is defined as 'any occurrence that is outside the norms or any happening that is not consistent with the routine operation of the center or care of a particular patient' .Some examples .are Falls .Found on floor . Unexplained bruising .All patient incidents should be documented in the EHR [electronic health record] . Injury is defined, for reporting purposes, as Significant injury including: Fracture or dislocation of bones or joints .Any condition requiring medical treatment outside the center that is inconsistent with the routine management of the patient's preexisting condition .The DON [Director of Nursing] should review all incidents for accuracy and complete documentation .is data complete and thorough and paints a picture of what happened .Was hospitalization necessary to treat the patient .Was the care plan updated to reflect the incident .Is additional investigation needed to determine the exact events of the incident .What can be done to avoid similar incidents recurring on this or any patient in the center .The data may be used for occurrence trending and improvement/prevention by the Safety Committee and QAPI [Quality Assurance Performance Improvement] Committee . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Local infection of the skin and subcutaneous tissue, Acute Respiratory Failure with Hypoxia, Metabolic Encephalopathy, Muscle Wasting and Atrophy, Unspecified Dementia, Contusion of right lower leg, and History of falling. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. Continued review revealed Resident #3 required extensive assistance of two plus person physical assistance for bed mobility, transfer, toileting, personal hygiene, and limited assistance of one person for dressing. Continued review revealed Resident #3 had limitation in range of motion with both lower extremities. Further review revealed Resident #3 had a fall in the last 2-6 months. Review of the Safety Events (Incident Report) revealed Resident #3 had an unwitnessed fall in her room and sustained a bruise on right abdomen on 11/3/2022.?Resident #3 had two additional unwitnessed falls in her room on 11/7/2022, and 11/23/2022. Resident #3 had 3 falls during 11/2022. 1 of 3 falls resulted in injury. Review of the Safety Events revealed Resident #3 had unwitnessed fall in her room on 12/29/2022. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room on 2/17/2023, after staff had placed her back in center of bed 3 times prior to the fall. Resident #3 had an unwitnessed fall on 2/21/2023 at 2:30 AM and sustained bruising on her right elbow and both knees. Resident #3 had a second unwitnessed fall in her room on 2/21/2023 at 6:15 AM which resulted in discoloration and tenderness to bilateral patella and bruising to her hand. Resident #3 had a third fall on 2/21/2023 at 8:10 PM and sustained small half dollar shaped red/bruised area to both kneecaps. Resident #3 had an unwitnessed fall in her room on 2/27/2023. Resident #3 had 5 falls during 2/2023. 3 of 5 falls resulted in injury. Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room on 3/6/2023 at 3:14 AM and sustained bruising on both knees. Resident #3 had an unwitnessed fall in her room on 3/11/2023, and sustained bruising to her left wrist. Resident #3 had 2 falls during 3/2023. 2 of 2 falls resulted in injury. Review of the Quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score of 4, which indicated severe cognitive impairment. Continued review revealed Resident #3 required extensive assistance of two plus person physical assist for bed mobility, transfers, dressing, toileting, personal hygiene, and was totally dependent for locomotion on and off unit and bathing. Further review revealed Resident #3 had 2 falls with no injury and 2 falls with injury since prior assessment. Review of the Safety Events revealed Resident #3 rolled out of bed while Certified Nursing Assistant (CNA) was in the process of changing the resident on 4/3/2023 and sustained a skin tear to her right hand. Resident #3 had an unwitnessed fall off low bed to fall mat on 4/13/2023. Resident #3 had been restless, agitated, talking loudly, delusional, and seeing men in her room prior to the fall. Resident #3 had an unwitnessed fall on 4/29/2023, and sustained skin tear on left forearm. Resident #3 had 3 falls during 4/2023. 2 of 3 falls resulted in injury. Review of the Safety Events revealed Resident #3 was found lying on the ground in front of her geriatric chair (a large, padded chair that can be reclined for comfort) while sitting at nurses' station on 5/6/2023 at 11:25 PM and sustained a large hematoma to her right forehead, eye orbit, and temple. Resident #3 had an unwitnessed fall in her room on 5/9/2023. Resident #3 was found in the floor after an unwitnessed fall in her room on 5/16/2023. Resident #3 was found sitting with her back by the bed after an unwitnessed fall in her room on 5/25/2023. Resident #3 had 4 unwitnessed falls during 5/2023. 1 of 4 falls resulted in injury. Review of the Safety Events revealed Resident #3 was found on the floor next to her bed after an unwitnessed fall on 6/4/2023. Resident #3 was found sitting beside her bed after an unwitnessed fall on 6/11/2023. Resident #3 was found sitting in floor after an unwitnessed fall in her room on 6/16/2023. Resident #3 was found on the floor in her room after an unwitnessed fall on 6/18/2023. Resident #3 had bruising under her left eye the following day on 6/19/2023. Resident #3 had an unwitnessed fall in her room on 6/21/2023. Resident #3 had 5 unwitnessed falls in her room during 6/2023. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Nhc Healthcare, Murfreesboro		STREET ADDRESS, CITY, STATE, ZIP CODE 420 N University St Murfreesboro, TN 37130	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Psychiatric Progress Notes dated 6/19/2023 revealed, .[Resident #3] tells writer that there are 'two men' in her room .they have been there all morning and is unsure why they are in her room or how they got there .Discussed VH [visual hallucinations] with her and she admits that sometimes her mind plays tricks on her .she [Resident #3-with severe cognitive impairment] agrees to believe staff if they tell her there is no one in her room . Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room and sustained 2 small bruises on each patella with bilateral knee pain, bruising to left hand on 2nd, 3rd, and 4th fingers at knuckle on 7/2/2023. An X-ray was obtained on 7/3/2023, results were positive for a fracture to right hip. Resident #3 had an unwitnessed fall in her room on 7/5/2023. A CNA heard Resident #3's clip on alarm and was unable to answer the alarm in time to prevent the fall. Resident was placed back in bed without further intervention. Resident #3 had unwitnessed fall in her room on 7/21/2023. Resident #3 had 3 falls during 7/2023. 1 of 3 falls resulted in major injury. Review of the Progress Notes for Resident #3 dated 8/6/2023 revealed, .Patient confused and climbing out of bed. Delusional, crying . Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room on 8/12/2023. Resident #3 had an unwitnessed fall in her room on 8/14/2023 and sustained bruising on her left knee with bilateral knee pain. Resident #3 had 2 falls during 8/2023. 2 of 2 falls resulted in injury. Review of the comprehensive care plan for Resident #3 dated 9/15/2023, revealed, .Transfer via [by way of] [named mechanical lift] and 2 person assist . Review of the Progress Notes for Resident #3 dated 9/21/2023 revealed, .pt having inc [increase] behaviors, crying and trying to get out of chair, explaining pt that there is no man, reassuring pt she is safe but unable to reorient her .PRN [as needed] diazepam [antianxiety medication given for anxiety] . Review of the Psychiatric Progress Note for Resident #3 dated 9/21/2023 revealed, .She tells writer that she did not sleep well last night but she cannot tell me why she had difficulty sleeping .She has periods of increased confusion, agitation, aggression and crying spells .Nursing report that she had increased behaviors last night with crying, trying to get out of her chair and talking about a 'man' . Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room on 9/1/2023, and was confused, agitated, and unable to be redirected. Resident #3 had a witnessed fall from her chair while sitting in front of the nursing station on 9/2/2023. Resident #3's clip alarm sounded upon nurse entering the room, resident was up unassisted. The nurse was unable to get to resident in time and resident sat upright on fall mat on 9/25/2023. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Progress Notes for Resident #3 dated 9/28/2023 revealed, .4:49 PM Pt seen by NP [Nurse Practitioner], has shingles. Contact precautions initiated . Review of the Progress Notes for Resident #3 dated 9/29/2023 revealed, .1:50 PM .Pt requires private room isolation for shingles-pt has cognitive deficit and does not understand precautions. She is not able to understand to avoid picking at skin and then touching other surfaces, roommate, or other people. Staff attempt to keep areas covered but pt is able to self-remove and adjust coverings. All care and services provided in pt's private room . Resident #3, a severely cognitively impaired resident with a history of multiple unwitnessed falls with injury, was relocated for isolation purposes to a room that was approximately 38 feet from the nurse station which was located on a separate hall. Review of the Safety Events revealed Resident #3 was up unassisted in her room and a CNA (Certified Nursing Assistant) walked in and had to lower her to the floor on 9/30/2023 at 8:00 AM. Resident #3 was placed back in the bed. Resident #3 had an unwitnessed fall in her room [ROOM NUMBER] hours later and sustained a large hematoma noted on her right lower extremity (RLE) with pain rated 8 out of 10 (pain scale of 1-10 with 10 being the highest pain level) in her leg. Resident #3's injuries required transfer to the local emergency room for evaluation. Review of Hospital #1's History and Physical dated 9/30/2023 for Resident #3 revealed, .medical history of dementia .paroxysmal A-Fib [Atrial Fibrillation] on Eliquis [blood thinner], history of DVT/PE [Deep Vein Thrombosis/Pulmonary Embolism] present from nursing home to hospital after a fall .patient was in shingle isolation at nursing home, had unwitnessed fall this morning. Nursing facility states they are unsure what happened exactly .Patient is requiring high amount of pain medication for leg pain .Reviewed CT [Computed Tomography] scan including CTA [Computed Tomography Angiography] lower extremity right showed large hematoma .ongoing small arterial bleeding [most severe and urgent type of bleeding which can result from a penetrating injury or blunt trauma] .Hematoma of right lower leg .Primary diagnosis is an acute or chronic illness with a high risk disease process that poses a threat to life or bodily function in the near term without treatment .Dementia .Severe, oriented to person. Also has sundowning . Review of Hospital #1's Consult Notes dated 10/1/2023 for Resident #3 revealed, .She came in from a nursing home status post a fall .history, she sustained an unwitnessed fall because she was in insolation [isolation] secondary to a shingles diagnosis. She is on Eliquis for Afib .physical examination today .right lower extremity has a 15cm [centimeter] x [by] 10 cm hematoma along the medial calf with serous blisters . fall was unwitnessed .facility states they are unsure of when it exactly happened .CTA was ordered and showed a hematoma measuring 22cm x 11.4cm x 6.5cm with multiple areas of contrast with ongoing bleeding . Review of a pictures provided by Family Member (FM) G dated 10/3/2023 at 11:24 AM, (3 days after Resident #3's fall at facility) revealed a large hematoma with swelling noted covering the top of her right lower leg. A picture dated 10/8/2023 at 2:09 PM revealed, the hematoma was black in color with the appearance of necrotic tissue. Review of medical records revealed Resident #3 was readmitted to the facility on [DATE]. Review of the Safety Events revealed Resident #3 had an unwitnessed fall in her room on 10/9/2023. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan for Resident #3 dated 10/9/2023, revealed .Pt recently returned from hospital and is in new room closer to nurses station; reorient to new environment . (Resident #3 had severe cognitive impairment) Review of a picture provided by FM G dated 10/10/2023 at 1:08 PM, revealed a circular bruise to Resident #3's lower left leg. Review of the Safety Events revealed a nurse heard Resident #3's clip alarm going off and Resident #3 was found sitting on her buttocks after an unwitnessed fall in her room on 10/11/2023. Review of the comprehensive care plan for Resident #3 dated 10/11/2023, revealed, .Encourage pt to sit in common areas such as nurses station, tv [television] room while up in chair to increase staff supervision . Resident #3 with dementia and was totally dependent on a mechanical lift and 2-person assist could not be encouraged but rather needed staff assistance to stay in common areas for closer staff supervision. Resident #3 had 28 unwitnessed falls in her room before 10/11/2023. Review of the Progress Notes dated 10/15/2023 at 12:27 AM revealed, Resident #3 had moments of confusion and hallucinations. Resident #3 stated that a fire was nearby and able to each the building. Review of the Safety Events revealed on 10/15/2024 at 12:45 AM, Resident #3's bed alarm sounded. Resident #3 had increased anxiety and confusion and staff noted she wanted to get out of bed because a fire was approaching. Review of the Safety Events revealed on 10/17/2023, .CNA was getting ready to transfer pt to her chair and when she turned her back to but [put] the pad in the chair pt slide out of low bed onto the mat with her buttocks . Resident #3 was care planned for use of a mechanical lift with 2 persons for all transfers. The event note above does not indicate a second person available for transfers present in the room. Review of the comprehensive care plan for Resident #3 revealed, .10/17/2023 .When pt anxious and agitated use x2 staff assistance with ADL [Activities of Daily Living] care . Resident #3 had an unwitnessed fall in her room on 10/18/2023. Resident #3 was found lying face down and tilted to right side at foot of geri chair. Resident #3 had skin tear to left elbow and bruising to inner right forearm. On 10/20/2023, CNA walked into Resident #3's room and resident was found lying on mat beside bed. Review of a picture provided by FM G dated 10/23/2023 at 10:12 AM, revealed Resident #3's clip alarm was unattached from the resident, lying next to the TV. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly MDS dated [DATE] revealed Resident #3 had a BIMS score of 4, which indicated severe cognitive impairment. Resident #3 had functional limitation in range of motion in upper and lower extremities on both sides. Resident #3 was dependent for toileting, upper and lower body dressing, personal hygiene, roll left and right, and chair/bed-to-chair transfer. Resident #3 had an acute diagnosis of Contusion of right lower leg. Resident #3 had 1 fall with no injury and 1 fall with injury since the prior assessment. ?Resident #3 had a bed alarm used less than daily. Review of a picture provided by FM G dated 10/26/2023 at 1:53 PM, Resident #3's clip alarm was laying on top of sheets not clipped to anything. During an interview on 7/29/2023 at 4:00 PM, the Social Service Director (SSD) stated, .I do remember the daughter having concerns about the fall with injury, but I really don't remember the details . Observation on the 100 hall on 7/31/2024 at 3:00 PM, revealed room [ROOM NUMBER]B (the room Resident #3 was relocated to for isolation and had a fall with a major injury on 9/30/2023), was the last room on the hall approximately 38 feet from the nurse station which was located on a separate hall. During a telephone interview on 7/29/2024 at 7:30 PM, FM G stated, .[Resident #3] fell out of bed .it caused a big hematoma .she had to have several surgeries to debride it .the facility couldn't tell me how long she had been in the floor .it never healed up .she was in severe pain every time they changed the bandage .I never could get an explanation out of them [facility staff] .when I would come to visit her the alarm was either on the table or not hooked up to her gown .I never saw [Resident #3] remove it .I would go in and they wouldn't have it hooked up .after all this happened [fall with Arterial Bleed] the staff wouldn't get [Resident #3] up and she just got worse .I talked to the Director of Nursing and the Administrator .I never seen anything improve and then they put her in that back corner in the rehab part to isolate her because they thought she had shingles .[Resident #3] was supposed to have a low bed but it wasn't always in the low position .she just kept declining and then she passed away . Review of pictures provided by FM G revealed undated pictures of Resident #3 with bruising noted to her right temple area close to her hair line, above her right eye, down the right side of her face, and bruising to back of ear and down her neck. FM G stated, I lost some of my phone information, but that picture was taken around 9/2023. During an interview on 7/31/2023 at 4:25 PM, MDS Coordinator/Quality Assurance (QA) Nurse stated, . [Named Resident #3] had severe dementia, very restless .was dependent with transfers .the care plan on admission has assist with ADLs per patient needs and preferences .[Resident #3] was impulsive on her own and her range of motion was impaired . The MDS Coordinator/QA Nurse reviewed the therapy notes and confirmed Resident #3 was dependent for transfers with a mechanical lift using 2 persons. The MDS Coordinator/QA Nurse stated nursing staff could review care plans in the computer and she expected staff to follow interventions related to resident care. During an interview on 7/31/2024 at 5:15 PM, the Physical Therapist (PT) stated, .her [Resident #3] transfer during the evaluation was a [Named mechanical lift] with 2 assist .she had limitation in her range of motion in her lower extremities and could not hold a movement .when we saw her in 7/2023, we recommended use of a [Named mechanical lift] . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 7/31/2024 at 5:20 PM, CNA K confirmed Resident #3 was a fall risk and required use of a mechanical lift using 2 persons assist for transfer. During an interview on 7/31/2024 at 5:30 PM, Licensed Practical Nurse (LPN) L stated, .the CNAs and nurses can look in the computer at the care plan to see how much assistance a resident need with care .you always need 2 people if you are getting someone up with a lift . During an interview on 7/31/2024 at 5:35 PM, CNA M stated, .I cared for [Named Resident #3] .She would try to get up without help .very restless . During an interview on 7/31/2024 at 8:50 PM, CNA N stated, .I was charting when I heard [Named Resident #3]'s bed alarm sound, when I opened the door, she was in the floor .a bruise was on her right leg where she hit the table .I know she had to hit the overbed table because it was beside the bed .the table was scooted across the floor in front of her . During an interview on 8/1/2023 at 11:00 AM, LPN I stated, .I was here the day she [Resident #3] fell [9/30/2023] .the 8:00 AM fall, [Resident #3] said she was getting up to get something out of the dresser .the CNA found her up and had to lower her to the ground .the second fall happened in her room .she was found on the floor .when I assessed her, the right leg had started getting red and swelling . During a telephone interview on 8/1/2024 at 1:54 PM, FM O stated, .the facility called me when [Resident #3] had the fall 9/30/2023 .[Resident #3] got at the ER about the same time I did .she was shaking and hurting so bad .[Resident #3] said she laid in the floor and hollered for help .[Resident #3] was crying and said I didn't think they would come get me .she was begging for someone to come kill her she was hurting so bad . they had to sedate her in the ER .She was in that room all the way at the end of the hall away from the nurse's desk with the door closed .she had so many falls since she had been there .the Administrator called me the next day .she couldn't tell me how long she laid in the floor or what time for sure it happened . During a telephone interview on 8/1/2023 at 2:00 PM, CNA P stated, .I was told when I came in after [Named Resident #3] fell [9/30/2023], she had been trying to get up and they found her in the floor and the staff didn't know how long she had been in the floor .I found her clip alarm not clipped several times .I would tell them her alarm wasn't on .the staff was very aware of her fall risk . During a telephone interview on 8/1/2024 at 2:28 PM, the Activity Staff stated, .I done some in room stuff with [Named Resident #3] she didn't come to group activities much .I don't remember any meetings we had where they discussed a specific activity plan for her .I just encouraged her to come to group activities . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/2/2024 at 8:40 AM, Medical Director stated, .[Named Resident #3] had Afib that is why she was on Eliquis [blood thinner] .constantly trying to get up, [Resident #3] just couldn't remember she couldn't walk anymore and needed help .the hematoma was a complication from the Eliquis .I vaguely remember her being put on isolation .dementia was a contributing factor .she was placed in a room at the end of the hall to limit the people going by the room . The Medical Director was asked why he felt limiting people going by the room would be necessary to stop the spread of Shingles. The Medical Director stated, .it was a reasonable decision to make .it's more commonly spread by touch .less traffic better idea . The Medical Director was asked if a special focus, trending, or tracking was performed for Resident #3 since she had numerous falls with injuries. The Medical Director stated, .I can't recall .falls happen no way to prevent falls . During an interview on 8/2/2024 at 4:30 PM, the Administrator was asked if the facility considered placing the resident in isolation so far from the nurse's station could have contributed to her falls. The Administrator stated, .the family met with us after the fall, and they voiced concerns about her being moved at the end of the hall, we moved her back closer to the nurse's desk . The Administrator was asked if the Interdisciplinary Team had performed any tracking, trending, root cause analysis, or developed a specific activity plan related to Resident #3's multiple (over 30) unwitnessed falls in her room, with various injuries (including two major injuries). The Administrator stated, .just what we have given you and what is in the chart .I don't know of anything else .she was on a low bed, fall mat, everything was in place already .she was never transferred out to the psych unit . During an interview on 8/2/2024 at 4:45 PM, the Interim DON was asked to review Resident #3's care plan and her fall event for 10/17/2023. The Interim DON confirmed Resident #3 required use of a mechanical lift with 2 persons assist. The Interim DON stated the CNA was trying to prepare to transfer Resident #3 on 10/17/2023 when the resident slid off the bed and stated, .I think any fall could be prevented with another person but maybe she was just getting her ready .