STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445136	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Putnam County	278 Dry Valley Rd Cookeville, TN 38506

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49786 Based on facility policy review, medical record review, and interview, the facility failed to revise a care plan to include fall interventions after 2 falls for 1 resident (Resident #40) of 4 care plans reviewed for falls. The findings include: Review of the facility policy titled, Comprehensive Care Plans, revised 2/9/2024, revealed .facility will develop and implement a person centered care plan for each resident, that includes measurable objectives and time frames to meet resident's medical, nursing, mental, and psychosocial needs .maintains a comprehensive care plan participate in the development of and reviewing and revising of the Comprehensive Care Plan . Review of the facility policy titled, Falls, revised 1/31/2025, revealed .A comprehensive Care Plan will be implemented based on the resident's risk for falls .interventions will be revised as applicable, with each new review . Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Hypertension, Chronic Kidney Disease, Cerebral Infarction (stroke), Hemiplegia (total or partial paralysis of one side of the body), Difficulty Walking, and other abnormalities of gait and mobility. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed the resident scored a 6 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Continued review revealed Resident #40 had impaired functional range of motion on one side of the upper and lower extremities. Resident #40 was dependent on staff for Activities of Daily Living (ADL) and for transfers. Resident #40 had a history of falls prior to admission. Review of a facility fall incident report for Resident #40 dated 8/25/2025, revealed .nurse was called to residents room per CNA [Certified Nursing Assistant] staff which reported Elder (Resident #40) was laying in the floor .observed him in the doorway of his room laying on his back feet facing the doorway, upper torso area resting in the leg rest of wheelchair. Elder stated he was trying to reach for something and was too far out .Elders seat cushion appeared to slide down with elder during the fall .New Interventions .remove cushion and move closer to nurses station . (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a care plan for Resident #40 dated 8/25/2024, revealed no intervention to include remove cushion and move closer to nurses' station. Review of a facility fall incident report for Resident #40 dated 8/27/2025, revealed .Elder found by staff lying in the floor at foot of bed with head slightly under chair. Stated that he was trying to get to his dresser .nurse spoke with NP [Nurse Practitioner] r/t [related to] elder stating to social services that he stays dizzy a lot . New Intervention .medication review r/t elder stating to staff he is dizzy when he gets up . Review of a care plan for Resident #40 dated 8/28/2024, revealed .Encourage elder to be active with activities and out of room . There was no intervention to include medication review r/t elder stating to staff he was dizzy when he gets up or interventions related to the resident's complaints of dizziness. Continued review revealed the care plan was not revised to include the fall interventions from the 8/25/2025 fall of moving the resident closer to the nurses' station or to remove the cushion from wheelchair. During an interview on 4/3/2025, at 11:00 AM the Director of Nursing (DON) confirmed on 8/25/2024, the fall intervention for Resident #40 was to remove the cushion and to move the resident closer to the nurses' station and the interventions were not updated on the care plan. The DON further confirmed on 8/27/2024 the fall intervention related to the resident's dizziness and the medication review was not added to the care plan. The DON confirmed Resident #40's care plan was not updated on 8/25/2024 or 8/27/2024 to reflect the newly established fall interventions.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50480

Based on facility policy review, medical record review, observations, and interviews, the facility failed to timely implement interventions to reduce the risk of falls for 1 resident (Resident #43) of 4 residents reviewed for falls.

The findings include:

Review of the facility's policy titled, Falls, revised 1/31/2025, revealed .ensure the facility provides an environment that is as free from accident hazards, as possible over which the facility has control to prevent avoidable falls .based on the resident's risk for falls .interventions specific to each resident to attempt to reduce the risk .

Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Dementia, Altered Mental Status, Muscle Weakness, Abnormal Walking and Mobility, and Mood Disorder.

Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #43 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment and required maximum staff assistance for standing and transfers.

Review of a Fall Event note dated 1/10/2025, revealed Resident #43 had a fall from the wheelchair in the hallway. Further review revealed Physical Therapy (PT) was to evaluate the resident's wheelchair as a new fall intervention.

Review of a PT Evaluation and Plan of Treatment dated 1/14/2025, revealed Resident #43 was added to the PT case load (4 days after the fall). Continued review revealed Resident #43 received PT services for wheelchair propelling, upright posture while seated in the wheelchair, falls, and leg strength training for mobility.

Review of a Fall Event note dated 2/16/2025, revealed Resident #43 had a fall from the wheelchair in the dining room. Further review of the Fall Event note revealed PT was to assess the resident for a different wheelchair as a new fall intervention.

Review of a PT Discharge note dated 2/21/2025, revealed Resident #43 was discharged from therapy services (evaluation was 5 days after the fall). Further review revealed no new assessment, or evaluation was conducted for a different wheelchair as the intervention for the fall on 2/16/2025.

Review of a Fall Event note dated 3/4/2025, revealed Resident #43 had a fall from the wheelchair. Further review revealed the fall intervention was for the resident's personal items to be moved closer to the resident for easier reach to prevent future falls.

Review of a comprehensive care plan intervention for falls dated 1/29/2025, revealed .keep personal items within reach . and was not a new intervention after the fall on 3/4/2025.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/1/2025 at 6:00 PM, Resident #43 was observed in the resident's room seated in a tilted wheelchair which contained an anti-thrust cushion. During a medical record review and interview on 4/2/2025 at 10:00 AM, the Director of Rehabilitation (DOR) reviewed the medical record for Resident #43 and stated Resident #43 started physical therapy services on 1/14/2025 related to frequent falls from the wheelchair. The DOR also stated a specialty wheelchair was recommended during therapy services for Resident #43 after the falls in 2/2025 but the wheelchair had not yet arrived to the facility. During an observation on 4/2/2025 at 10:07 AM, Resident #43 was observed in the dining room seated in a tilted wheelchair which contained an anti-thrust cushion. During a medical record review and interview on 4/3/2025 at 5:30 PM, the DON reviewed the medical record with the surveyor for Resident #43 and revealed the following: On 1/10/2025, the resident fell from the wheelchair and the intervention was for PT to evaluate. Resident #43 was not admitted to therapy services until 1/14/2025 (4 days after the fall). On 2/16/2025, the resident had a fall from the wheelchair and the new intervention was for PT to evaluate for a different (specialty) wheelchair. PT did not evaluate for a specialty wheelchair until 2/21/2025 (5 days after the intervention). The DON also stated the specialty wheelchair had not been delivered to the facility, and no other interventions had been implemented after the 2/16/2025 fall. On 3/4/2025, the resident had a fall from the wheelchair, the interventions were to move personal items for easier reach and was noted as an intervention on the care plan on 1/29/2025 and was not a new fall intervention. During an interview on 4/3/2025 at 6:30 PM, the DON confirmed the facility failed to timely implement fall interventions after the falls on 1/10/2025, 2/16/2025, and on 3/4/2025.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36003 Based on facility policy review, medical record review, facility documentation review, and interviews the facility failed to prevent loss or diversion of controlled medications (narcotics) for 1 resident (Resident #7) of 65 sampled residents reviewed for misappropriation of narcotics. The facility was cited as past non-compliance. Non-compliance began on [DATE] and ended on [DATE]. The facility is not required to submit a Plan of Correction for F-755. The findings include: Review of the facility's policy titled, Controlled Medications, dated [DATE], revealed .The facility will ensure Controlled Medications are handled, stored, disposed of, and recordkeeping is in place in accordance with federal, state, and other applicable laws and regulations .At each shift change or when keys are rendered, a physical inventory of all controlled medication is conducted by two staff members who are either licensed nurses, medication technicians, or appropriate staff per state regulations and is documented on the controlled medications accountability record .The licensed nurse .surrendering the keys along with the licensed nurse .assuming the keys will ensure the count of the remaining medication(s) match the medication accountability book. Both the licensed nurse .surrendering the keys along with the licensed nurse .assuming the keys will verify, together, the correct or incorrect accounting of medication(s). Any medication count discrepancies or medication card count discrepancies that can't be reconciled by the licensed nurse .need to be reported to the Director of Nursing (DON) immediately .Once the medication count is completed, both licensed nurses .will also count the number of individual narcotic control sheets, together and will sign the controlled medication accountability record .If a new medication is added or a medication is discontinued/removed, the controlled medication accountability record must reflect the above by completing the controlled medication accountability record by two licensed nurses . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Heart Failure, Psychotic Disorder with Delusions, Vascular Dementia with Psychotic Disturbance, and Chronic Pain. The resident expired in the facility on [DATE]. Review of an admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 scored 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident was cognitively intact. The resident received opioids. Review of the physician's orders dated [DATE] for Resident #7 revealed .oxycodone-acetaminophen [opiod pain medicine] XXX,d+[DATE] mg [milligrams]; amt [amount] .10mg; oral [by mouth] Every 4 Hours - PRN [as needed] . Discontinued [DATE]. Review of a pharmacy shipping manifest (invoice) dated [DATE], revealed the facility received 90 oxycodone-acetaminophen,d+[DATE] tablets for Resident #7. Continued review revealed Licensed Practical Nurse (LPN) B received and signed for receipt of the medication on [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of pain assessments for Resident #7 revealed the resident's pain levels on a scale of ,d+[DATE] (0 being no pain and 10 being the worst possible pain) revealed: [DATE]: day shift-0 night shift-0 [DATE]: day shift-2 night shift-0 [DATE]: day shift-3 night shift-1 [DATE]: day shift-3 night shift-0 [DATE]: day shift-0 night shift-0 [DATE]: day shift-0 night shift-0 Review of the medication administration record for Resident #7 revealed the resident received Oxycodone-Acetaminophen ,d+[DATE] mg for pain as follows: [DATE] at 8:09 AM; 12:28 PM; 4:53 PM; and 10:11 PM [DATE] at 11:29 AM and 4:47 PM [DATE] at 7:50 AM and 12:00 PM [DATE] at 4:49 AM; 9:03 AM; 1:23 PM; and 8:31 PM Review of the facility's documentation dated [DATE], revealed the facility reported the following information to the state designated authority: .Allegation Type .Misappropriation of Resident Property .staff became aware of the incident XXX[DATE] [at] 1:00 PM .Alleged Victim .[Resident #7] .Alleged Perpetrator .unknown . On [DATE], a bubble pack card of 30 Oxycodone/Acet. [Acetaminophen] ,d+[DATE] .noted to be missing during a count of narcotics .Upon counting of narcotics, it was noted that [Resident #7] was missing one card [of 30 tablets] of his Oxycodone. He still had a remaining card of medications and had not missed any doses . Review of a police report dated [DATE], revealed .Crime Incidents Theft Of Property (theft From Building) . On [DATE], [named officer] dispatched to [facility] in regards to missing medication .[Facility Administrator] explained the situation that medication had been missing from the building .[facility] noticed the medication gone at 1:30 PM today. The medication was 10mg Oxycodone and a whole bubble pack was gone. A bubble pack contains 30 Oxycodone. She stated that she was in contact with the company that delivered them on [DATE]th to see if it was a miscount and would call back on [DATE]th if they were found or the company's count was incorrect. She stated that the charge nurses are the ones assigned to the medicine carts and are the only ones that have access to the medications . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:33 PM, the Director of Nursing (DON) stated she became aware 1 card (30 tablets) of Oxycodone,d+[DATE] mg for Resident #7 was missing when she pulled discontinued controlled medications from the medication cart on the 100 hall on [DATE]. The DON stated .I counted .I did not get the same number she [Registered Nurse-RN A] got .[RN C] counted the sheets [individual resident narcotic record] while I counted the cards [cards with medications/bubble packs]. The numbers were not adding up to what was in the book [controlled medication accountability record] .[RN A] pulled out [Resident #7's card of 60 [oxycodone] and said he's missing his card of 30 [oxycodone] . During a telephone interview on [DATE] at 5:50 PM, RN A stated she and LPN B counted the hall 1 medication cart narcotics the morning of [DATE]. RN A stated she counted the pills on the card and LPN B checked the individual resident's narcotic record/sheet to ensure the pill count was correct. RN A stated LPN B .was in a rush and had to get her kids to school . RN A stated she and LPN B did not count the medication cards and individual resident narcotic record/sheets together the morning of [DATE]. During a telephone interview on [DATE] at 7:46 PM, LPN B stated the process for counting narcotics included the oncoming and off going nurse counted the cards/bubble packs in the cart and the individual resident narcotic records to ensure the numbers were the same. The pills in each card/bubble pack were to be counted and compared with the individual resident narcotic record to ensure the number of pills was the same as recorded on the resident's narcotic record. LPN B stated .We [LPN B and RN A] counted pills and counted the cards .the papers [individual resident narcotic record] were not counted .We did not count the papers that morning [[DATE]] . During an interview on [DATE] at 11:53 AM, the DON stated she became aware of the missing medication . around 11:30 AM [[DATE]], when I went to collect controlleds [narcotics] for destruction . The DON stated she and RN A counted the individual resident narcotic sheets and cards. Each counted 68 individual narcotic sheets and 68 cards/bubble packs instead of 69 (number indicated on the narcotic inventory shift count sheet for the morning count on [DATE]). The DON stated RN C and the Regional Nurse also counted 68 cards and 68 individual resident narcotic sheets. Continued interview revealed RN A, went through the cards and remembered Resident #7 was supposed to have 2 cards of oxycodone ,d+[DATE], 1 with count of 60 pills and 1 with count of 30 pills. The card of 30 oxycodone ,d+[DATE] was not in the medication cart. The DON stated when medication cart keys exchanged hands, the expectation was 1 nurse counts the pills on the cards and the other nurse compares the pill count with the number documented on the individual resident narcotic sheet. The nurses verbalize the count to ensure the numbers match. At the end of the count, the nurses do a full count of cards and individual resident narcotic sheets .both numbers have to match . The DON stated both nurses were to sign the inventory shift count sheet to confirm the count was completed and was accurate. Staff were expected to notify clinical leadership if there was a discrepancy in the counts. The DON stated .one of the steps [card count and individual narcotic record sheet count] was not completed accurately . The DON confirmed RN A and LPN C did not verify the narcotic count was accurate and confirmed the facility's controlled medications policy was not followed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on [DATE] at 10:50 AM, the pharmacy representative stated the pharmacy received a script for Resident #7 for Oxycodone ,d+[DATE] mg, 90 tablets on [DATE]. The pharmacy representative stated the Oxycodone was delivered to the facility, were checked in and signed for by facility staff on [DATE]. The pharmacy representative stated the facility notified the pharmacy the card of Oxycodone for Resident #7 was missing on [DATE]. Continued interview revealed the pharmacy performed a narcotic count which verified the pharmacy's narcotic count was correct and confirmed 90 tablets of Oxycodone for Resident #7 had been sent to the facility on [DATE]. During an interview on [DATE] at 11:53 AM, the Administrator and DON confirmed the facility had identified the misappropriation of property for Resident #7 and had taken actions to correct the non-compliance. A plan of correction was developed to address the deficient practice identified. The corrective actions were validated on-site by the surveyor on [DATE]-[DATE] through interviews and review of facility documents. The facility's Plan of Correction for Misappropriation of Property was presented to the survey team and documented the following corrective actions were implemented: On [DATE], Resident #7, who had a BIMS of 15 was interviewed and assessed for pain with no pain noted or reported. There were 60 Oxycodone/Acetaminophen ,d+[DATE] mg tablets were available for administration. Resident #7 missed no doses of the PRN Oxycodone/Acetaminophen. Pain assessments for uncontrolled pain were completed for all residents on Hall 1. Results concluded there were no residents with uncontrolled pain. Residents on Hall 1 with a BIMS equal to or greater than 8 were interviewed to determine if their pain was controlled and PRN medication had been administered when requested. All residents reported their pain was controlled and they had received their pain medication when requested. On [DATE], the pharmacy was informed of the missing medications for Resident #7. The pharmacy replaced the 30 tablets of Oxycodone/Acetaminophen ,d+[DATE] mg for Resident #7 at the cost of the facility. On [DATE] and [DATE], controlled medications were reconciled on every medication cart by the DON, Assistant DON (ADON) , or Wound Care Nurse with no findings of additional medication count discrepancies. On [DATE], urine drug screens were performed for RN A and LPN C with negative results. RN A and LPN C were suspended pending results of the investigation. Controlled medication records for all residents in the facility from [DATE]-[DATE] were audited from [DATE]-[DATE]. Results concluded there were no other residents with missing medications. All staff were interviewed on [DATE]-[DATE] to inquire if they had knowledge of controlled medication unaccounted for or if they had suspicion of anyone working while impaired. There were no findings from the interviews. On [DATE]-[DATE], all staff received education regarding the Abuse and Misappropriation policy. Any staff/agency staff who were not educated were to be educated prior to working their next shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE]-[DATE], all licensed staff received education on the Controlled Medication Policy and process changes for counting/receiving/removing controlled medication. The process included: .The Director of Nursing will remove all controlled medications with a witness (empty and discontinued) from the medication cart, reconcile the Controlled Substance Count Sheets and compare the Controlled Substance Count Sheets to the Controlled Drug Records as they are removed from the cart to be secured for destruction. No one will remove controlled medication card/sheets without the Director of Nursing, Assistant Director of Nursing or wound nurse witnessing . Every nurse completed a competency on medication pass started on [DATE] and was completed on [DATE]. Any licensed staff, including agency nurses, who were not education were to be educated prior to working their next shift. Beginning [DATE], the DON or designee observed every nurse complete a narcotic count competency. On [DATE], the DON or designee began auditing licensed nurse's complete narcotic counts at shift change during varying shift 5 times/week for 2 weeks, the 3 times/week for 4 weeks, and then 2 times/week for weeks. On [DATE], the DON or designee began auditing pharmacy delivery reports to ensure the delivered controlled medications were accurately added to the medication carts and controlled substance count sheets: 5 deliveries/week times 2 weeks, then 3 deliveries/week times 4 weeks, then 2 deliveries/week for 4 weeks. Ad Hoc QAPI meetings were held on [DATE], [DATE], [DATE], and [DATE]. QAPI meetings were held weekly beginning [DATE] for 4 weeks, then 2 times/month for the next 30 days, then monthly or until the QAPI Committed determined substantial compliance had been achieved. Audit results revealed no further concerns of misappropriation of resident property. The facility continued to perform random monthly audits. 1. Surveyor interviewed the Administrator and DON on [DATE] at 11:53 AM, in the Administrator's office. Interview confirmed there had not been any further incidents involving loss or diversion of resident controlled medications. 2. Surveyor interviewed multiple licensed staff members (day shift and night shift) for knowledge of the in-services provided in the corrective action plan, and no knowledge deficits were identified. 3. Observations of several narcotic audits performed by licensed nursing staff revealed the staff followed proper procedure for reconciling controlled medications. The deficient practice was cited as past noncompliance for F-755 and the facility is not required to submit a plan of correction.