

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445154	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/07/2026
NAME OF PROVIDER OR SUPPLIER Quality Center for Rehabilitation and Healing LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 932 Baddour Parkway Lebanon, TN 37087	
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)		
<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the National Library of Medicine article review, Black Box Warning review, the facility's Licensed Practical Nurse Job Description review, policy review, facility documentation review, medical record review, observation, and interview, the facility failed to ensure all nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely for 2 of 4 (Resident #11 and #12) sampled residents. The findings include: 1. Review of the article from the National Library of Medicine titled, Midazolam, dated 7/6/2025, revealed, .Midazolam [Versed] is a short-acting benzodiazepine [central nervous system depressant drugs that slow brain activity, used for short relief of anxiety and sedation prior to medical procedures] frequently used for sedation.Midazolam also provides anxiolysis [relieving anxiety].Adverse event risk, including respiratory depression, hypotension [decrease blood pressure].Monitoring vital signs, including blood pressure, heart rate, and respiratory rate, is necessary.Monitoring is essential for older patients. 2. Review of the undated Black Box Warning revealed, .Black Box Warning Details Order: Midazolam HCL [Hydrochloric acid] Injection Solution 5 MG [milligram] /5ML [milliliter].Warning .Midazolam has been associated with profound sedation, respiratory depression, and respiratory arrest .In some cases, where this was not recognized promptly and treated effectively, hypoxic encephalopathy [brain injury from lack of oxygen or blood flow], coma, and death have resulted .provide continuous monitoring of respiratory and cardiac function.Lower doses are necessary for older (over 60 years) or debilitated patients. 3. Review of facility's Licensed Practical Nurse (LPN) Job Description revealed, .Administers treatments and other direct care .Observes and evaluates residents' responses to medications .Communicates educational needs .maintain competency and improve knowledge and skills .Incorporate evidenced-based gerontological knowledge into practice .Have critical thinking skills .make role-appropriate decisions .Apply best practices in the care of persons with cognitive loss . 4. Review of the undated facility policy titled, Nursing Services, revealed, .The medical care of each resident is under the supervision of a Licensed Physician and carried out through the nursing department .The nursing department.participates in the resident's assessment.monitoring changes in resident's medical status.The nursing department.along with the provider will perform pertinent medical assessments, for example taking vital signs as ordered as needed. 5. Review of a typed memo (completed by the DON and sent via a team's chat) dated 7/15/2024, revealed, Ativan [antianxiety medication] IM [intramuscular] is on national back order .there maybe times that the pharmacy is able to fill this request for resident specific orders but it will NOT be in the medbank [emergency stat box] anytime soon That said.Versed.will be used in its place. It is in the [NAME] [benzodiazepine-class of depressant drugs that slow down the central nervous system] drug class and FDA [Federal Drug Administration] approved for anxiety/agitation in low doses. Respiratory status will be [need] to be monitored when this is given. Please make yourself familiar with this</p> <p>(continued on next page)</p>		

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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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>medication . 6. Review of the medical record revealed Resident #11 admitted to the facility on [DATE], with diagnoses which included Dementia, Alzheimer's Disease, Major Depressive Disorder, and Psychosis. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #11 had a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. Resident #11 had no noted behavior during the assessment period. Review of the Order Summary dated 5/14/2025, revealed .Midazolam HCL . Injection Solution 5 MG/ML [Milligrams per Milliliter] .Inject 2.5 mg [milligrams] intramuscularly one time only for Agitation for 1 Day . Review of the Progress Notes dated 5/14/2025, revealed, .13:12 [1:12 PM].Increased aggression/agitation towards staff and residents. This resident stating I'm going to kick your.I have money, I'm going to pay for an attorney Attempted to redirect resident from crowded area, unsuccessful. Resident refusing p.o. [by mouth] med [medication].Np [Nurse Practitioner].notified, new order received Midazolam 2.5mg [milligrams] IM one time only for increased behaviors. Review of the Medication Administration Record (MAR) dated 5/2025, revealed Versed 2.5 mg IM injection was administered at 12:54 PM on 5/14/2025, by LPN T. Review of the Weights and Vitals Summary for 5/2025, revealed no blood pressure, heart rate, or respirations were obtained prior to or after the administration of Versed on 5/14/2025. 7. Review of the medical record revealed Resident #12 admitted to the facility on [DATE], with diagnoses which included Dementia, Mood Disorder, and anxiety disorder. Review of the admission MDS dated [DATE], revealed Resident #12 had a BIMS score of 6, which indicated severe cognitive impairment. Resident #12 had no noted behavior during the review period. Review of the Progress Notes dated 9/19/2025, revealed, .16:28 [4:28 PM].Resident has increased anxiety this shift. PRN [as needed] ativan not effective, combative with staff, non-complaint with care. Very difficult, sometime not at all redirectable. Unable to sit still. Refusing hydration, snacks, environmental changes, conversation.Will continue to try other avenues. Reported to in house NP, new order provided. Review of the Order Summary dated 9/19/2025, revealed .Midazolam HCL .Injection Solution 5 MG/ML .Inject 0.25 milliliter intramuscularly one time only for anxiety for 1 Day . Review of the MAR dated 9/2025 revealed Versed 2.5 mg IM injection was administered at 5:49 PM on 9/19/2025, by LPN V. Review of the Progress Notes dated 9/19/2025, revealed, .17:53 [5:53 PM].New order for versed.1x [one time] dose r/t [related to] increased anxiety. Review of the Weights and Vitals Summary dated 9/2025 revealed no vitals were obtained prior to or after the administration of Versed on 9/19/2025. During an interview on 10/1/2025 at 5:55 PM, the DON was asked what she would expect the nursing staff to monitor for after a resident was given Versed. The DON stated, .No decline in their respiratory status, going up or down [referring to breathing].do they appear in distress. The DON was asked if she would expect vital signs to be completed with monitoring prior to and after the Versed was given. The DON stated, .if the resident needed that. The DON verified that a memo dated 7/15/2024, related to the use of Versed was sent out to all nurses working at the time by a secure application advising that Resident's respiratory status would need to be monitored when the medication was used, but did not specify a time frame for the monitoring. The DON stated, .I did not set a time frame, if they look at them and they appear to need an assessment, it is a case-by-case basis. The DON acknowledged no further training was provided to the nursing staff related to the administration of Versed besides the memo dated 7/15/2024. During an interview on 10/2/2025 at 12:20 PM, the Medical Director was asked what he would expect the nursing staff to monitor for with the administration of Versed. The Medical Director stated, .monitor, use your nursing judgement.Versed usually out of system in hour and half, 2.5 mg was least effective dose .a 3-hour window of monitoring. During an interview on 12/2/2025 at 12:50 PM, LPN T acknowledged she was aware of the black box warning for the administration of Versed and verified a full set of vitals should be</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>completed when giving Versed. During an interview on 12/2/2025 at 1:33 PM, LPN V confirmed no vital signs were obtained for Resident #12 when she administered the Versed on 9/19/2025. During an interview on 1/6/2026 at 11:10 AM, NP #4 acknowledged Residents should have vital signs before and after the administration of Versed and should be watched closely and monitored for changes in their breathing.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, Job Description review, medical record review, and interview the facility failed to provide pharmaceutical services that assured a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate account of medication destruction for 4 of 4 (Resident #8, #10, #11, and #12) sampled residents reviewed for drug destruction. The findings include: 1. Review of a facility policy titled, Emergency Medications, dated 4/2007, revealed .The facility shall maintain a supply of medications typically used in emergencies.The emergency medication supply will include medications that are needed in providing treatment in the immediate need per physician's order.Accessing the emergency medications supply requires 2 nurses to be present to witness the dispensing/wasting of the medication when required. Review of undated facility policy titled, Controlled Substances, revealed, .The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II [controlled substances under the United Stated Controlled Substances Act that have a high potential for abuse] and other controlled substances.When controlled substances are received, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance.This record must contain: Name of the resident.Name and strength of the medication.Quantity received.Number on hand.Name of provider.Date received.Time of administration.Signature of nurse administering medication. Review of the facility policy titled, Pharmacy Services Overview, dated 2001 revealed, .Policy Interpretation and Implementation .The facility shall contract with a licensed Pharmacist to help obtain and maintain timely and appropriate pharmacy services .This includes .disposal, documentation, and reconciliation of all medications .in the facility . 2. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Psychosis, and Wandering. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #8 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Resident #8 had no noted behaviors over the assessment period. Review of the Order Summary dated 12/10/2024, revealed .Midazolam HCL [a central nervous system depressant drug that slows brain activity, used for short relief of anxiety and sedation prior to medical procedures] . Injection Solution 5 MG [milligram] / [per] ML[milliliter] .Inject 2.5 mg intramuscularly one time only for agitation for 1 Day . Review of the emergency stat box (med bank) pull list dated 12/10/2024, revealed a 1 ml vial of Midazolam 5 mg/ml was pulled for Resident #8. Review of the Medication Administration Record (MAR) dated 12/2024, revealed Midazolam 2.5 mg (0.5ml) IM injection was administered on 12/10/2024 at 2:45 AM, by LPN O. The facility was unable to provide documentation of the receipt of the medication and the disposal of the unused Midazolam for Resident #8. 3. Review of the medical record revealed Resident #10 admitted to the facility on [DATE], with diagnoses which included Cerebral Infarction, Vascular Dementia, and Depression. Review of the Order Summary dated 12/6/2024, revealed .Midazolam HCL Injection Solution 5 MG/ML .Inject 2 mg intramuscularly one time only for Anxiety for 1 Day . Review of the med bank pull list dated 12/6/2024, revealed a 1 ml vial of Midazolam 5 mg/ml was pulled for Resident #10. Review of the Medication Administration Record (MAR) for Resident #10 dated 12/2024, revealed Midazolam 2 mg IM (0.4 ml) injection was administered on 12/6/2024 at 9:45 PM, by LPN U. Review of the Order Summary dated 12/7/2024 revealed, .Midazolam HCL . Injection Solution 5 MG/ML .Inject 0.4 ml intramuscularly one time only for agitation/anxiety for 1 Day . Review of the med bank pull list dated 12/7/2024, revealed a 1 ml vial of Midazolam 5 mg/ml was pulled for Resident #10.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the MAR dated 12/2024, revealed Midazolam 2 mg (0.4 ml) IM injection was administered on 12/7/2024 at 9:19 PM by LPN U. Review of the admission MDS dated [DATE], revealed Resident #10 had a BIMS score of 9 which indicated moderate impaired cognition. Resident #10 had physical and verbal behaviors directed toward others which significantly interfered with the residents care over the last 7 days. The facility was unable to provide documentation of the receipt of the medication and the disposal of the unused Midazolam for Resident #10. 4. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses which included Dementia, Alzheimer's Disease, Major Depressive Disorder, and Psychosis. Review of the quarterly MDS dated [DATE], revealed Resident #11 had a BIMS score of 5 which indicated severe cognitive impairment. Resident #11 had no noted behavior during the assessment period. Review of the Order Summary dated 5/14/2025, revealed .Midazolam HCL . Injection Solution 5 MG/ML .Inject 2.5 mg intramuscularly one time only for Agitation for 1 Day . Review of the med bank pull list dated 5/14/2025, revealed a 1 ml vial of Midazolam 5 mg/1 ml was pulled for Resident #11. Review of the MAR dated 5/2025, revealed Midazolam 2.5 mg (0.5 ml) IM injection was administered on 5/14/2025 at 12:54 PM by LPN T. The facility was unable to provide documentation of the receipt of the medication and the disposal of the unused Midazolam for Resident #11. 5. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses which included Dementia, Mood Disorder, and Anxiety Disorder. Review of the admission MDS dated [DATE], revealed Resident #12 had a BIMS score of 6 which indicated severe cognitive impairment. Resident #12 had no noted behavior over the assessment period. Review of the Order Summary dated 9/19/2025, revealed .Midazolam HCL .Injection Solution 5 MG/ML .Inject 0.25 milliliter intramuscularly one time only for anxiety for 1 Day . Review of the med bank pull list dated 9/19/2025, revealed a 1 ml vial of Midazolam 5 mg/1 ml was pulled for Resident #12. Review of the MAR dated 9/2025, revealed Midazolam 2.5 mg (0.5ml) IM injection was administered on 9/19/2025 at 5:49 PM by LPN V. Review of the Order Summary dated 9/29/2025 revealed, .Midazolam HCL Injection Solution 5 MG/ML .Inject 2.5 mg intramuscularly one time only for anxiety for 1 Day . Review of the MAR dated 9/2025, revealed Midazolam 2.5 mg IM injection was administered on 9/29/2025 at 1:15 PM by LPN V. Review of the med bank pull list dated 9/29/2025 revealed no Midazolam was pulled for Resident #12. The facility was unable to provide documentation of the receipt and reconciliation of the Midazolam for Resident #12. During a telephone interview on 10/1/2025 at 11:11 AM, the Pharmacist stated, .The nurse would have to have an order, it can't be a verbal, the NP would have to write the script and ask dispensing pharmacy. During a telephone interview on 10/1/2025 at 1:50 PM, the (Named Pharmacy) representative stated, .the Med bank was on a different hall than [Named Resident #8] it is not uncommon for one nurse to pull the medication to bring to another hall if it's an emergency situation.a 2nd nurse to watch the nurse waste it. During an interview on 10/1/2025 at 4:05 PM, LPN O was asked about obtaining the Versed from the emergency med bank for Resident #8.an LPN did pull the versed for me [referring to pulling the medication from the emergency med bank].the box was on her hall and if we are having a difficult time with a patient they will bring the meds down to us. LPN O was asked if a narcotic sheet was completed when the Versed was pulled from the emergency med bank. LPN O stated, .I don't remember a narcotic sheet. During an interview on 12/2/2025 at 12:50 PM, LPN T was unable to recall if a narcotic sheet was completed for the Versed administered to Resident #11 on 5/14/2025 at 12:54 PM. During an interview on 12/2/2025 at 1:33 PM, LPN V verified a narcotic sheet was not completed for the Versed administered to Resident #12 on 9/19/2025 and 9/29/2025. During an interview on 12/3/2025 at 4:09 PM, the DON was asked if she had any narcotic sheets for the Versed being pulled from the</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>emergency med bank showing the Versed was pulled by 2 nurses and extra medication was wasted for Resident #8, Resident #10, Resident #11, and Resident #12. The DON stated, .we don't keep them.we shred the narcotic sheet. During an interview on 12/11/2025 at 7:11 PM, the DON was asked where LPN V obtained the Versed to administer to Resident #12 on 9/29/2025, since no medication was pulled from the emergency med bank. The DON stated, ,[Named Resident #12] was having a lot of behaviors. That nurse [LPN V] saved the versed in the med cart and 10 days later she gave the medication to her. The DON was asked if Resident #12 had a PRN (as needed) order for the versed prior to 9/29/2025. The DON stated, .No, it was just a one-time order. The DON acknowledged the nurse should have wasted the medication instead of storing the Versed on the medication cart.</p>		