STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445166	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Health Center at Richland Place	504 Elmington Avenue Nashville, TN 37205

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to promote privacy for 2 of 5 (Resident #1 and Resident #4) sampled residents reviewed for dignity. The findings include: 1. Review of the facility's Patient Rights document in the admission handbook dated 9/2024, revealed .PRIVACY.we provide you with privacy so that you may maintain a dignified existence, self-determination, and communication with and access to persons and services inside and outside the center.People not directly involved in your medical care will not be present without your consent.Privacy is also maintained during toileting, bathing and other activities of personal hygiene.Each center shall respect a patient's right to the use and quiet enjoyment of his or her personal room.patient's shall have the right to close the door to their room if they wish. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Acute Respiratory Failure, Congestive Heart Failure, and Nicotine Dependence. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Observation in the Resident's room on 8/5/2025 at 8:30 AM, revealed Resident #1 was eating breakfast and visiting with a friend as Licensed Practical Nurse (LPN) C opened the door and entered the resident's room without knocking or asking permission to do so. During an observation and interview in Resident #1's room on 8/5/2025 at 11:45 AM, LPN C walk into Resident #1's room without knocking on the door or asking permission to enter, stepped into bathroom, then came out without speaking to Resident #1. Resident stated, They do that almost daily, come right on in without asking. Observation in Resident #1's room on 8/6/2025 at 9:00 AM, revealed Resident #1 sat on her bed talking on her cell phone as CNA H opened the door without knocking or asking permission to enter. CNA H proceeded to go into Resident #1's bathroom to wash her hands then she exited the room without speaking to the resident. Observation in Resident #1's room on 8/6/2025 at 12:15 PM, revealed Resident #1 speaking to Nurse Practitioner, as Case Worker I opened door and entered Resident #1's room, without knocking or asking permission to enter. Case Worker I turned around and left the room without speaking to Resident #1. 3. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Dependence on Supplemental Oxygen, Chronic Obstructive Pulmonary Disease, and Anxiety. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. During an observation and interview in Resident #4's room on 8/6/2025 at 12:30 PM, Resident #4 was sitting in bed feeding herself and family was at the bedside, as CNA J opened the door and entered the room without knocking or asking permission to enter. CNA J went into the bathroom put something in the garbage can and turned and left without speaking to Resident #4. Resident #4 confirmed the staff do not knock and ask permission to enter her room each time. During an interview on 8/6/2025 at 1:45 PM, the Director of Nursing confirmed staff should knock on the residents' door and ask for permission before entering a resident's room.

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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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen administration and failed to store, change, and date respiratory supplies for 2 of 3 (Resident #1 and #2) sampled residents reviewed for respiratory care. The findings include; Review of the facility's policy titled, Oxygen Administration, dated 2001, revealed .The purpose of this procedure is to provide guidelines for safe oxygen administration.Verify that there is a physician's order for this procedure. Review the physician's orders.for oxygen administration.Portable oxygen cylinder (strapped or secured in a stand). Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Pneumonia, Acute Respiratory Failure, Congestive Heart Failure, and Nicotine Dependence. Review of the admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. Review of the Physician's Order dated 7/22/2025, revealed .Oxygen at 4-6 L/min [Liters per minute] via [per] nasal cannula every shift. Oxygen equipment maintenance once a day on Tues [Tuesday].Special Instructions: Change connector and humidity bottle; have new respiratory bag at bedside. Observation and interview in Resident #1's room on 8/4/2025 at 4:45 PM, revealed an inhalation nebulizer machine at bedside laying on the resident's dressing table at the end of her bed. The mask was laying on the table not covered. Resident #1's oxygen concentrator was at the bedside on 3 liters oxygen per binasal cannula (3 L/min BNC) with a long undated oxygen tubing on the floor. A full unsecured portable oxygen cylinder was sitting on the floor at the end of the resident's bed. Resident #1 was asked when her oxygen tubing was changed. Resident #1 stated, They gave me this on the day I was admitted . During an interview on 8/4/2025 at 5:05 PM, Registered Nurse (RN) A was asked how often the oxygen tubing is to be changed and should it be dated. RN A stated .I think its weekly.the respiratory therapist changes the tubing, and the oxygen supplies, we don't do that.I don't know about the dating of tubing. RN A was asked how many liters of oxygen Resident #1 was ordered and if the portable oxygen cylinder should be in the resident's room unsecured. RN A stated, 4 to 6 liters of oxygen.I will check her settings. the portable cylinder should be in a stand. Observation in Resident #1's room on 8/5/2025 at 8:30 AM, revealed a nebulizer breathing treatment machine at bedside with a nebulizer mask covered with a dried white thick substance inside the mask, laying on the table uncovered, and the oxygen tubing was undated and on the floor. The oxygen concentrator was set on 3L/min BNC. A full portable unsecured oxygen cylinder was sitting at the end of the Resident #1's bed. During an interview on 8/5/2025 at 9:00 AM, LPN A was asked what oxygen setting was ordered for Resident #1 and if the tubing should be dated. LPN A stated, She [Resident #1] is usually on 5 liters of oxygen.I will check her settings.Nurses don't change the tubing, respiratory does that, but I think the respiratory therapist has been off. LPN A was asked if Resident #1 was on respiratory treatments, and should the mask be covered. LPN A stated .She doesn't have an order for respiratory treatments.she shouldn't have the nebulizer at her bedside.but the mask should always be covered when not in use. LPN A was asked if the full unsecured portable oxygen cylinder should be in the resident's room. LPN A stated, No, not without a stand. 2. Review of medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Dependence on Supplemental Oxygen, Chronic Obstructive Pulmonary Disease, and Anxiety. Review of annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. Review of the Physician Order dated 2/27/2025, revealed .ipratropium-albuterol solution for nebulization; 0.5 mg [milligram]/ [per] 3 ml [milliliter].every 6 hours PRN [as needed]. Review of Physician Order dated 6/6/2025, revealed .Oxygen at 2-4 L/min via nasal cannula. Review of the Physician Order dated 7/16/2025, revealed .Oxygen equipment maintenance once a day.Change and date oxygen tubing, connector and humidity bottle; have a new respiratory bag at bedside. Observation in Resident #4's room on 8/5/2025 at 11:30 AM and 4:45 PM, revealed the oxygen tubing and humidifier water bottle with no date, and a nebulizer mask with a thin film of white substance on the inside of the mask, laying on the bedside table that was not covered. During an interview on 8/5/2025 at 5:00 PM, LPN B was asked if the oxygen tubing and humidifier water bottle should be dated and if the nebulizer mask should be covered. LPN B stated, I think it should be dated.the RT [Respiratory Therapist] is responsible for that.the nebulizer mask should be covered or in a plastic bag. During a telephone interview on 8/6/2025 at 12:30 PM, the Respiratory Therapist (RT) was asked should a portable full oxygen cylinder be stored in a resident room. The RT stated

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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. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to ensure Physician Orders were written and documented when 1 of 3 (Resident #1) sampled residents received medications without a written Physician Order for a respiratory breathing treatment. The findings include: 1. Review of the facility's policy titled, MEDICATION ADMINISTRATION-GENERAL GUIDELINES dated 2/25/2025, revealed . Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .Before administering a medication, the nurse should assure he/she is administering to the correct patient, verify the medication, dose, time and route .The medication administration record (MAR) is always employed during medication administration .the physician's orders are checked .Medications are administered in accordance with written orders of the prescriber . Review of the facility's Patient Rights document in the admission handbook revised 9/2024, revealed .MEDICATION AND TREATMENT DECISIONS .Medical Oversight .Medications and treatments are ordered by and given under the general supervision of your attending physician . Review of the facility's policy titled, PATIENT CARE POLICIES, revised 3/2025, revealed .RESPIRATORY THERAPY .including inhalation therapy, will be given only upon the order of a physician or physician extender . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Pneumonia, Acute Respiratory Failure, Congestive Heart Failure, and Nicotine Dependence. Review of the admission Minimum admission Data Set (MDS) dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. During observation and interview in Resident #1's room on 8/5/2025 at 10:30 AM, Resident #1 asked for a respiratory breathing treatment. The facility's Nurse Practitioner (NP) entered room and stated to Resident #1 that she didn't feel like she needed a breathing treatment related to it would increase her heart rate. Resident #1 stated she received a breathing treatment the day before, pointing to her respiratory breathing treatment machine at her bedside. Review of the Resident #1's medical record revealed no Physician's Order for respiratory treatments. Review of Resident #1's MAR dated 7/2025 and 8/2025, revealed no documentation related to receiving a respiratory treatment. During an interview on 8/5/2025 at 11:15 AM, Licensed Practical Nurse (LPN) A confirmed no Physician Order or documentation of a respiratory treatment was noted in Resident #1's medical record. During observation and interview on 8/6/2025 at 8:30 AM, Resident #1 stated she would like to have a respiratory breathing treatment since she had one last night. Review of Resident #1's medical record revealed no documentation of a respiratory treatment administered. During an interview on 8/6/025 at 8:45 AM, Registered Nurse (RN) A confirmed she gave Resident #1 a respiratory treatment on 8/4/2025. RN A stated, .I don't see a Physician Order for respiratory treatments in her chart . RN A was asked did she see documentation of the resident's lung sounds or vital signs documented in her medical record or where she did receive the respiratory treatment. RN A stated, No I don't see any documentation of that . RN A was asked if she administered a respiratory treatment to Resident #1 without a Physician Order. RN A stated, Yes. RN A was asked if she documented the assessment of the Resident's lung sounds or vital signs before and after her respiratory treatment. RN A stated, No. RN A was asked should she administer medications without a written physician's order and should that be documented in the medical record. RN A stated There should be an order, and the respiratory treatment should be documented .as well as lung assessment before and after . During an interview on 8/6/2025 at 9:00 AM, the Director of Nursing (DON) confirmed Resident #1 received respiratory treatments on 8/4/2025 and 8/5/2025 without a Physician's Order. The DON stated, Residents should have a written Physician Order prior to administering medications and the medical record should document all medications administered. During an interview on 8/6/2025 at 1:30 PM, the Nurse Practitioner (NP) was asked should a resident receive medications without a Physician Order. The NP stated, Of course not .I completed an assessment today and she [Resident #1] had rales to both lower lobes [lungs] so she can now have respiratory treatments every 4 hours as needed for shortness of breath .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to promote privacy of medical records for 2 of 3 (Resident #1 and Resident #3) sampled residents reviewed during medication administration. The findings include: Review of the facility's Patient Rights document dated 9/2024, revealed .MEDICAL RECORDS.A record kept of Physician's Orders, Progress Notes and Professional documentation which is called your Medical Record.your personal and medical records are kept confidential and are used only by individuals involved in your care. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Pneumonia, Acute Respiratory Failure, Congestive Heart Failure, and Nicotine Dependence. Observation on 2nd floor short hall across from the elevators on 8/4/2025 at 4:10 PM, revealed a medication cart with the laptop open showing Resident #1's personal information and medications on the laptop screen. During an interview on the 2nd floor across from the elevators on the short hall on 8/4/2025 at 4:18 PM, Registered Nurse (RN) A was asked should Resident #1's personal information and the medication administration record (MAR) be visible for staff and visitors to see. RN A stated, No, I thought I had it [laptop] closed most of the way. Observation during medication administration on 8/4/2025 at 4:55 PM, revealed RN A walked away from the medication cart and into Resident #1's room, while leaving Resident #1's medical record visible on the laptop screen. The Nurse was asked if the laptop MAR should be visible exposing the Resident's personal information. RN A stated No.it shouldn't have been. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypertension, and Orthopedic aftercare of Laminectomy/fusion. Observation on the 2nd floor outside of Resident #3's room on 8/5/2025 at 3:50 PM, revealed RN B walked away from his medication cart during medication administration, leaving his laptop open exposing Resident #3's personal information and MAR on the laptop screen. During an interview on 8/5/2025 at 5:10 PM, RN B was asked should the Resident's (Resident #3) private information including his MAR be left exposed for staff and visitors to see. RN B stated, No. During an interview on 8/6/2025 at 9:10 AM, the Director of Nursing confirmed the Residents' private information and MARs should not be exposed for staff and visitors and visitors to see.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, Centers for Disease Control and Prevention Guideline (CDC) review, observation, and interview, the facility failed to ensure practices to prevent the potential spread of infection were maintained for medication administration for 3 of 3 (Resident #1, #2 and #3) sampled residents reviewed receiving medications, when 3 of 3 nurses (Registered Nurse (RN) A, RN B, and Licensed Practical Nuse (LPN) C) failed to clean the site prior to administering a transdermal patch, failed to perform hand hygiene before and after glove use, and failed to disinfect re-usable equipment. The findings include: 1. Review of the facility's policy titled, Hand Hygiene, dated 2/2025, revealed .PURPOSE .To decrease the number of microorganisms, preventing cross contamination between staff and patients .Provide hand hygiene before and after contact with each patient .and before and after removal of gloves . Review of the facility's policy titled, SPECIFIC MEDICATION ADMINISTRATION PROCEDURES: Transdermal Drug Delivery System (Patch) Application dated 2/25/2025, revealed .Wash hands or use facility-approved sanitizer .cleanse area of old patch with a clean water wet gauze and pat dry with another gauze pad if needed .Cleanse area where new patch will be placed using clean water wet gauze pad and pat dry with another gauze pad if needed . Review of the CDC Guidelines dated 3/24/2024, revealed .Considerations for Reducing Risk of infections. re-usable equipment must be cleaned before and after each patient use. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Acute Respiratory Failure, Congestive Heart Failure, and Nicotine Dependence. Review of Resident #1's Physician Order dated 7/24/2025, revealed .Nicotine patch 24 hour: 7mg [milligram]/ [per] 24hr[hours]: 1 patch; transdermal .apply patch to a new area of skin daily .once a day . Observation in Resident #1's room on 8/4/2025 at 4:30 PM, revealed Registered Nurse (RN) A administering a transdermal patch. RN A failed to perform hand hygiene prior to applying gloves while applying the transdermal patch. RN A failed to clean Resident #1's upper arm prior to applying the medication patch. During an interview on 8/4/2025 at 4:50 PM, RN A was asked if the transdermal site should be cleaned prior to administering a medicated patch and when hand hygiene should be performed. RN A stated, Yes, I should have cleaned my hands before applying gloves and I should clean the site before applying the medication patch . 3.Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Contusion of Liver, Diabetes, and Hypertension. Observation in Resident #1'and Resident #2's room on 8/5/2025 at 8:27AM, revealed LPN C using a blood pressure cuff to obtain the residents' vital signs. After administering Resident #1's medications, LPN C proceeded to obtain Resident #2's (roommate) vital signs using the same blood pressure cuff on Resident #2 without cleaning the blood pressure cuff before and after each resident use. LPN C failed to perform hand hygiene after using the BP machine. LPN C exited the residents' room and returned to the cart and signed off the medical record without performing hand hygiene. During an interview on 8/5/2025 at 9:05 AM, LPN C was asked if the multi-use blood pressure cuff is cleaned between residents. LPN A stated, yes I try to, but I didn't do that and should have to prevent the spread of any kind of infection . LPN C was asked if she performed hand hygiene after contact with the BP machine or after contact with each resident. LPN C stated, No but I should . 4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Diabetes, Hypertension, and Orthopedic aftercare of Laminectomy/fusion. Observation in Resident 3's room on 8/5/2025 at 3:50 PM, revealed RN B preparing to obtain a glucometer check. RN B applied clean gloves without performing hand hygiene. RN B proceeded to clean the glucometer with a bleach wipe, put the glucometer down on a barrier, removed his dirty gloves, re-applied clean gloves, without performing hand hygiene, obtained an Accu-Chek, disposed of glucometer strip in sharps container, removed gloves then left the room without performing hand hygiene. RN B then put on clean gloves, without hand hygiene, to clean the used glucometer, he then removed dirty gloves and signed out his glucometer reading in the resident's medical record, and did not perform hand hygiene. During an interview on 8/5/2025 at 4:20 PM, RN B was asked if he should perform hand hygiene before and after donning and doffing gloves and after cleaning re-useable glucometer. RN B stated, Yes. During an interview on 8/6/2025 at 8:45 AM, the Director of Nursing (DON) confirmed hand hygiene should be performed before and after glove use. The DON confirmed the Licensed Nurse should clean a resident's skin prior to administering a transdermal patch and the staff should clean a multi-use BP cuff before and after each resident