STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445170	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Health and Rehab Center	500 Hickory Hollow Terrace Antioch, TN 37013

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, behavioral hospital record review, medical record review, hospital record review, and interview, the facility failed to protect the resident's right to be free from neglect for 1 of 4 (Resident #2) sampled residents reviewed. The facility failed to provide the necessary structure and processes to meet the care needs of Resident #2 when staff failed to effectively supervise and monitor for potential accident hazards, and provide a safe environment, which resulted in bodily injury. Resident #2 was admitted to the facility on [DATE] from a Behavioral Health Hospital where she had exhibited behaviors of eating non-food items which included items large enough to pose suffocation hazards. The facility had documentation which identified Resident #2's unusual behaviors of eating non-food items and failed to develop a person-centered plan of care which addressed and monitored the resident for continuing behaviors. According to documentation in the medical record on 6/25/2024, Resident #2 began to complain of difficulty swallowing with pain in her throat and chest (symptoms of adverse conditions caused from ingesting non-food items) and was not transferred to the hospital until 7/2/2024, 8 days later. Resident #2 was admitted to the hospital with multiple non-food items identified in her stomach and damage to her digestive tract and died on 7/9/2024. The facility's failure to provide the structure and processes to meet the care needs of Resident #2 resulted in an Immediate Jeopardy. Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, serious impairment, or death to a resident. The Administrator, Director of Nursing (DON), [NAME] President of Clinical Services (VPCS), and Regional Regulatory Compliance Officer (RRCO) were notified of the Immediate Jeopardy at F-600 during the complaint investigation on 10/3/2023 at 2:40 PM. The facility was cited Immediate Jeopardy at F-600 at a scope and severity of J, which is substandard quality of care. The Immediate Jeopardy began on 1/12/2024 through 10/8/2025 and was removed on 10/9/2025. An acceptable Removal Plan which removed the immediacy of the Jeopardy was received on 10/7/2025 and was validated onsite by the surveyor on 10/7/2025 through 10/8/2025 by medical record reviews, observations, review of education records, and staff interviews. A partial extended survey was conducted on 10/3/2025 through 10/9/2025. Noncompliance at F-600 continues at the scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the undated facility policy titled, Abuse, Neglect and Exploitation, revealed, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written.assure that staff assigned have knowledge of the individual residents' care needs and behavioral symptoms.The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.Addressing features of the physical environment that may make abuse, neglect.of a resident.more likely to occur.Sudden or unexplained changes in behaviors and/or activities such as fear of a person or place, or feelings of guilt or shame. 2. Review of the medical record revealed Resident #4 was admitted to the Behavioral Health hospital on [DATE] for further evaluation related to being a danger to herself. Review of the Behavioral Health Hospital's Progress Note dated 11/22/2023, revealed .No foreign body identified in stomach (she [Resident #2] apparently had reported to nursing that she had swallowed a fork) . Review of the Behavioral Health Hospital's Progress Note dated 11/24/2023, revealed .Patient [Resident #2] was placed on one-to-one level of observation last night due to attempting to choke herself with a toothpaste tube. Review of the Behavioral Health Hospital's Progress Note dated 11/25/2023, revealed .pt [Resident #2] attempted to put crackers up her nose and gauze in her mouth. Review of the Behavioral Health Hospital's Progress Note dated 11/28/2023, revealed .Patient [Resident #2] exhibits ongoing behaviors and attempted to put sugar in her ears this morning.she requires frequent re-direction to maintain her safety. Review of the Behavioral Health Hospital's Progress Note dated 11/30/2023, revealed .[Resident #2] attempts to place items in her ears and

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Health and Rehab Center	500 Hickory Hollow Terrace Antioch, TN 37013

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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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility incident report review, staffing agency timeslip review, Metropolitan Police Department Public Record Request Response review, and interviews, the facility failed to conduct a thorough investigation for allegations of sexual abuse for 1 of 4 (Resident #4) sampled residents reviewed for abuse. On 3/6/2024, Resident #4 reported she was sexually assaulted by a man fitting the description of an agency employee working in the facility. Resident #4 reported the male entered her room, pulled his penis out, turned her over and stuck his penis in her rectum. The facility's failure to thoroughly investigate allegations of sexual abuse to determine if necessary actions were needed to ensure the protection of all residents from abuse resulted in Immediate Jeopardy (IJ) for Resident #4. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing (DON), the [NAME] President of Clinical Services (VPCS), and the Regional Regulatory Compliance Officer (RRCO), were notified of the Immediate Jeopardy (IJ) at F-610 during the complaint investigation on 10/3/2023 at 2:42 PM. The facility was cited at F-610 at a scope and severity of J, which is Substandard Quality of Care. A partial extended survey was conducted from 10/3/2025 through 10/9/2025. An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F-610 was received on 10/7/2025. The Removal Plan was validated onsite by the surveyor on 10/7/2025-10/8/2025 through medical record review, observation, review of education records, and staff interviews. The IJ began on 3/6/2024 - 10/8/2025 and was removed on 10/9/2025. Noncompliance at F-610 continues at the scope and severity of E for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.The findings include: Review of the undated facility policy titled, Abuse, Neglect and Exploitation, revealed, .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.Sexual Abuse is non-consensual sexual contact of any type with a resident .Alleged Violation is a situation or occurrence that is observed or reported by staff, resident.visitors or others but has not yet been investigated.mental faculty; requiring medical intervention as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse.Criminal sexual abuse is serious bodily injury/harm shall be considered to have occurred if the conduct causing the injury is conduct described. relating to aggravated sexual abuse.The facility will follow the State and federal guidelines for investigating and reporting.An immediate investigation is warranted when suspicion of abuse, neglect.or reports of abuse, neglect.occur.Identifying staff responsible for the investigation.Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations.Focusing the investigation on determining if abuse, neglect.mistreatment has occurred, the extent, and cause.Providing complete and thorough documentation of the investigation.The facility will make efforts to ensure all residents are protected from physical and psychosocial harm.Responding immediately to protect the alleged victim and integrity of the investigation.Taking all necessary actions as a result if the investigation, which may include.Analyzing the occurrence(s) to determine why abuse, neglect.of resident. and what changes are needed to prevent further occurrences.Training of staff on changes made, and demonstration of staff competency after training is implemented .Identification of staff responsible for implementation of corrective actions.The expected date for implementation.Identification of staff responsible for monitoring the implementation of the plan.The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses which included Peripheral Vascular Disease, Anxiety Disorder, Acquired Absence of Right Leg Above Knee, and Acquired Absence of Left Leg Above Knee. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Resident #4 was dependent on staff for toileting hygiene, lower body dressing, and transfers, and was incontinent of bowel and bladder. Review of the Temporary Staffing Agency's signed time slips provided by the facility revealed Certified Nursing Technician (CNT) Z worked in the facility assigned to the 200 Hall where Resident #4 resided. On 3/4/2024, CNT Z was assigned to the 200 Hall during the 6:30

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, employee file review, National Weather Service statistics review, Grievance Log review, Hospital documentation review, medical record review, police report review, and interview, the facility failed to ensure a safe environment and provide adequate supervision to prevent elopement for 1 of 5 (Resident #3) sampled residents reviewed. Resident #3, a severely cognitively impaired resident with known exit seeking behaviors, who was incontinent and dependent for toileting hygiene and supervision for eating, left the facility through a window in his room. The facility was unaware Resident #3 was missing, alone and unattended from the facility for an undetermined length of time. The last known time Resident #3 was seen in the facility was approximately 10:30 PM on 3/29/2024, 18 hours before being located at approximately 4:00 PM on 3/30/2024, 5.1 miles away from the facility beside a busy 5 lane, high traffic street which resulted in Immediate Jeopardy for Resident #3. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, serious impairment, or death to a resident. The Administrator, Director of Nursing (DON), [NAME] President of Clinical Services (VPCS), and Regional Regulatory Compliance Officer (RRCO) were notified of the Immediate Jeopardy at F-689 during the complaint investigation on 10/3/2023 at 2:43 PM in the Administrators office. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J, which is substandard quality of care. The Immediate Jeopardy began on 3/30/2024 through 10/8/2025 and was removed on 10/9/2025. An acceptable Removal Plan which removed the immediacy of the Jeopardy was received on 10/7/2025 and was validated onsite by the surveyor on 10/7/2025 through 10/8/2025 by medical record reviews, observations, review of education records, and staff interviews. A partial extended survey was conducted on 10/3/2025 through 10/9/2025. Noncompliance at F-689 continues at the scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Elopement/Wandering, Unsafe Resident, dated 3/30/2024, revealed .The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement.staff will identify residents who are at risk for harm because of unsafe wandering.staff will assess at-risk individuals for potentially correctible risk factors related to unsafe wandering.resident's care plan will indicate the resident is at risk for elopement.Interventions to try to maintain safety will be included in the resident's care plan. Nursing staff will document.wandering, by a resident.Staff will institute a detailed monitoring plan. 2. Review of the employee file for Certified Nursing Technician (CNT) X revealed multiple disciplinary progressive action forms and statements of verbal warnings to include failure to provide care and services to residents during the 10:30 PM to 6:30 AM shift. CNT X's progressive discipline notes included failure to provide assigned showers, sitting in a resident's room talking on the cell phone, failure to turn and reposition a resident until 4:00 AM during the 10:30 PM to 6:30 AM shift, and failure to answer call lights. 3. Review of the National Weather Service statistics revealed the recorded low temperature during the night of 3/29/2024 through the morning of 3/30/2024, the time of the elopement, was 54 degrees Fahrenheit. The high temperature on 3/30/2024 was 79 degrees Fahrenheit. 4. Review of the facility's Grievance Logs dated 5/2024 through 7/2025, revealed 22 complaints within 15 months related to staff not coming into resident rooms to provide care during the 10:30 PM to 6:30 AM shift, incontinent residents waiting hours for call lights to be answered, and staff turning off the call lights without providing care. Resolutions for these complaints was education provided to staff. 5. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses which included Metabolic Encephalopathy, History of Falling, Cocaine Abuse, Dementia, Viral Hepatitis B and C, Alcohol Abuse, Altered Mental Status, Restlessness and Agitation, and Needs Assistance with Personal Care. Review of a Progress Notes dated 1/23/2024, revealed .[Family Member-FM BB].stated that [Named Resident #3] had a Wander Guard [sensor that alarms when resident nears an exit to prevent elopement] on at [Named Facility #2] and he would need one here.She said when the weather is better, he will really want to go outside and enjoy the sunshine. A Wander Guard was placed on R [Right].Ankle. Review of the Wandering/Elopement Risk assessment dated [DATE], revealed Resident #3 ambulated independently, was cognitively impaired, expressed the desire to leave the facility, wandered aimlessly and sat next to exit doors. Resident #3 scored as high risk with 10 or more risk factors for an elopement from the facility. Review