STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445180	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Lawrenceburg	374 Brink Street Lawrenceburg, TN 38464

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 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** 51740 Based on policy review, medical record review, observation, and interview, the facility failed to provide an environment free of accident hazards related to elopement for 1 of 1 (Resident #33) sampled resident when Resident #33 was able to exit the facility without the knowledge of the staff. The findings include: 1. Review of the facility's policy titled, Wandering and Elopements, dated 2001, revealed .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents . Review of the facility's policy titled, .Incident and Accident Process, revised 8/13/2013, revealed . Investigation into the incident/accident .Obtain info [information] on what happened .Never move the patient until the assessment is completed unless immediate treatment is needed .Do first aid .Initiate neuro [neurological] checks if head struck or evidence of a patient striking their head .Document all known facts, results of assessment including a complete description of injuries, treatment .Review care plan for updated required related to a change/update .Accidents not resulting in injuries should still be reported . Documentation that addresses the status and/or progress of the patient in relation to the incident/accident is to be completed at least every shift for 72 hours . 2. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction with Hemiplegia, Altered Mental Status, Disorientation with Confusion, and Metabolic Encephalopathy. Review of Elopement Risk assessment dated [DATE] revealed Resident #33 had a score of 0. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicated Resident #33 was moderately cognitively impaired. Review of the Event Report dated 4/16/2025, revealed .Found on floor .Patient's w/c [wheelchair] was found in front of the front doors. He was found by the railing by doors attempting to get up. Patient stated that he was trying to get fresh air .Location of Fall .Outside on Center Grounds .Was Fall Witnessed .No . (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 Note dated 4/16/2025, revealed .Patient was found outside on ground near front door by staff member He stated that he wanted to get some fresh air and looking to see if his car was here. Instructed patient that he needs to be accompanied by staff member to go outside. Patient verbalized understanding .Patient has 2 abrasions .1 on each knee . Review of the Physician Orders dated 4/16/2025, revealed an order for wander guard, and to check wander guard placement every shift. Review of the Elopement Risk assessment dated [DATE], revealed Resident #33 had a score of 1, indicating Resident #33 was at risk for elopement. The facility failed to identify and investigate an elopement on 4/16/2025 for Resident #33. During an interview on 4/29/2025 at 2:30 PM, the Director of Rehabilitation confirmed she was at the front door and leaving the building for the day and observed an unoccupied wheelchair at the front door. The Director of Rehabilitation confirmed she began to look around to see who the wheelchair belonged to and observed Resident #33 unassisted and without staff outside of the facility on the ground to the right side of the metal handrail. The Director of Rehabilitation confirmed she yelled out to the Administrator to see if he was in his office with no answer and then used her cellular phone to call back into the facility for assistance. The Director of Rehabilitation confirmed the Administrator and the Director of Nursing (DON) arrived and a brief assessment of Resident #33 was conducted to his head, bilateral hips but she failed to look under his clothes. The Director of Rehabilitation confirmed that Resident #33 stated he was just trying to go out to get air and to check on his car. The Director of Rehabilitation confirmed that the front door is usually unlocked and if you push the door or press the exit button the door will open. During an observation and interview on 4/29/2025 at 2:53 PM, the Director of Rehabilitation measured the distance where Resident #33 was observed on the ground outside of the facility. The Director of Rehabilitation confirmed upon measurement that Resident #33 was found at approximately 10 feet on the ground from the front entrance. During an interview on 4/29/2025 at 3:16 PM, Certified Nursing Assistant (CNA) B confirmed Resident #33 did not display any exit seeking behavior until he was witnessed outside of the facility on 4/16/2025 without staff assistance or knowledge. During interview on 4/29/2025 at 3:39 PM, the DON confirmed she received a call indicating that Resident #33 was found outside of the facility at the front door unassisted and without staff knowledge. The DON confirmed that she and the Administrator responded to the call and went to the front door entrance and found Resident #33 on the ground outside of the front door. The DON confirmed that Resident #33 had abrasions to both knees. The DON confirmed that the front doors remain unlocked from 7 AM to 7 PM and anyone can come and go freely. The DON confirmed they failed to identify and investigate an elopement for Resident #33. The DON confirmed that Resident #33 was moderately cognitively impaired and should not have been outside without staff knowledge and assistance.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51671 Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to maintain an indwelling urinary catheter (a plastic tube inserted into the bladder to drain urine) when nursing staff failed to provide catheter care for an indwelling urinary catheter for 1 of 2 (Resident #32) sampled residents reviewed for the use of an indwelling urinary catheter. The findings include: 1. Review of the facility's undated policy titled CATHETER CARE, INDWELLING (MALE AND FEMALE), revealed .Indwelling Catheter Care will be provided once daily .Catheter care will be provided using approved techniques in order to decrease the risk of catheter-associated urinary tract infection. 2. Review of the medical record revealed Resident #32 was admitted to the facility on [DATE], with diagnoses including Alzheimer's, Dementia, Obstructive and Reflux Uropathy, Retention of Urine, and Functional Urinary Incontinence. Review of the quarterly Minimum Data Set assessment dated [DATE], revealed a Brief Interview for Mental Status score of 10, which indicated Resident #32 was moderately cognitively impaired, dependent on staff for toileting and bathing, required the use of an indwelling urinary catheter, and had an active diagnosis of obstructive uropathy. Review of the Care Plan dated 4/14/2025, revealed .Foley Catheter .At risk for complications r/t [related to] obstructive uropathy and urinary retention .Foley catheter care daily and prn [as needed] . Review of the Physician Orders for 3/1/2025-3/31/2025, revealed the facility failed to have orders for foley catheter care daily and prn for Resident #32. Review of the facility Treatment Administration Records (TAR) for March 2025 and April 2025, revealed no documentation of foley catheter care for Resident #32. Observation in Resident #32's room on 4/29/2025 at 1:49 PM and 4/30/2025 at 8:12 AM, revealed resident sitting up in chair with yellow urine draining to urinary catheter bedside bag. During an interview on 4/30/2025 at 3:28 PM, the Director of Nursing (DON) confirmed there should be an order for urinary catheter care when a resident has an indwelling urinary catheter. The DON confirmed Resident #32 has had an indwelling urinary catheter since 3/10/2025. The DON confirmed urinary catheter care should be done daily and if it is on the care plan it should be completed and on the TAR.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50408 Based on policy review, medical record review, observation, and interview, the facility failed to follow physician orders for oxygen for 1 of 3 (Resident #46) sampled residents reviewed for oxygen therapy. The findings include: 1. Review of the undated facility policy titled, RESPIRATORY: NASAL CANNULA, revealed .must perform an oxygen check and document .Verify physician order for liter flow, device of delivery and duration . 2. Review of the medical record review revealed Resident #46 was admitted to the facility on [DATE], with diagnoses including Oxygen, Chronic Obstructive Pulmonary Disease, Respiratory Failure, Dementia, Palliative Care, and Heart Failure. Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 99 with cognition skills severely impaired. Resident #46 also received oxygen therapy. Review of the Physician's orders dated 11/29/2024, revealed .Oxygen at 3 liters/min [minute] BNC [bi-nasal cannula] Every Shift . Observation in the resident's room on 4/28/2025 at 3:59 PM, 4:47 PM, 4/29/2025 at 7:43 AM, 10:39 AM, and 1:25 PM, and 5:35 PM revealed Resident #46 was lying in bed with head of bed elevated with oxygen at a flow rate of 2 liters/min. During an interview on 4/29/2025 at 4:55 PM, the Director of Nursing confirmed that oxygen flow rate should be set at the correct rate and that physician orders should be followed.