STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445237	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Church Hill Post-Acute and Rehabilitation Center	701 West Main Blvd Church Hill, TN 37642

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to ensure a resident or resident representative consented to the use of psychotropic medications prior to administration of the medication for 1 resident (Resident #19) of 5 residents reviewed for unnecessary medications.The findings include: Review of the facility's undated policy titled, Psychotropic Medication Use Guidelines, revealed .Residents and/or representatives shall be educated on the risks and benefits of psychotropic drug use, as well as alternative treatments/non-pharmacological interventions . Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Dementia, Psychosis, Depression, and Anxiety Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #19 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of a Medication Administration Record (MAR) dated 1/1/2026 - 1/31/2026, revealed .ClonazePAM [a psychotropic medication used to treat anxiety and agitation] .0.5 MG [milligrams] .Give 1 tablet by mouth three times a day related to ANXIETY DISORDER .Start Date .01/13/2026 . Further review revealed .RisperiDONE [Risperdal] [antipsychotic/psychotropic medication] .0.25 MG .Give 1 tablet by mouth three times a day related to UNSPECIFIED PSYCHOSIS .Start Date .1/27/2026 . Continued review revealed Resident #19 received the medications according to the provider's order. Review of a MAR dated 2/1/2026 - 2/11/2026, revealed .ClonazePAM .0.5 MG .Give 1 tablet by mouth three times a day related to ANXIETY DISORDER .Start Date .01/13/2026 . Further review revealed .RisperiDONE .0.25 MG .Give 1 tablet by mouth three times a day related to UNSPECIFIED PSYCHOSIS .Start Date .01/27/2026 .D/C [discontinue] Date .02/03/2026 .RisperiDONE .0.25 MG .Give 2 tablet by mouth three times a day [TID] related to UNSPECIFIED PSYCHOSIS .Start Date .02/04/2026 . Continued review revealed Resident #19 received the medications according to the provider's order. Review of a Consent form for Psychotropic Medications dated 2/11/2026 (29 days after the order was initiated), revealed .Medication 1 .Risperdal .0.25 mg 2 tab PO [by mouth] TID [three times daily] .Specific Target Behaviors .hallucinations, agitation .Medication 2 .Clonazepam 0.5 mg TID .Specific Target Behaviors .anxiety .agitation . Continued review revealed less restrictive non-drug approaches were proven to be ineffective, potential side effects, and expected duration of each medication was discussed. The consent was obtained from the resident's family member on 2/11/2026 (30 days after the start of the Clonazepam and 15 days after the start of the Risperidone). During an interview on 2/12/2026 at 1:22 PM, the Director of Nursing (DON) stated new medications and treatments were to be discussed with the resident or resident representative to make them aware of the risks and benefits and the consent was to be obtained prior to initiation of the medication by the nurse that received the new order. The DON stated Resident #19 was started on Clonazepam on 1/13/2026 and Risperdal on 1/27/2026 and the consent was not obtained by the resident's representative until 2/11/2026. The DON confirmed the consent was not obtained prior to the starting of the medications.

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, transportation calendar review, and interviews, the facility failed to notify a resident representative of appointments outside of the facility for 1 resident (Resident #1) of 3 resident families interviewed for notifications. The findings include: Review of the facility's undated policy titled, Transporting a Resident, revealed .Facility will ensure that residents who require an escort to appointments, due to cognitive or physical limitations, have arrangements made ahead of time. The facility will notify the family of the appointment . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Dementia, Cerebral Infarction (stroke), and Hemiplegia (paralysis of one side). Review of a comprehensive care plan for Resident #1 dated 10/22/2023, revealed .Cognition .I have problems with my memory and cognition . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. The resident required supervision/touching assistance with transfers and moving from sitting to standing position. Review of the transport calendar for 6/2025, revealed Resident #1 was transported for an outpatient physician/provider appointment on 6/26/2025. Review of a quarterly MDS assessment dated [DATE], revealed Resident #1 scored a 4 on the BIMS assessment which indicated the resident had severe cognitive impairment. Resident #1 required supervision/touching assistance with transfers and substantial/maximal assistance from sitting to standing position. Review of the transport calendar for 12/2025, revealed Resident #1 was transported for an outpatient physician/provider appointment on 12/4/2025. Review of an Appointment Communication form for Resident #1 dated 12/4/2025, revealed .Rx [treatment] Steroid Shots No New Rx just injections WBAT [weight bearing as tolerated] .Follow Up Appointment Scheduled for .3 months . Review of a Family Nurse Practitioner (FNP) note for Resident #1 dated 12/5/2025, revealed the resident .recently followed outpatient with orthopedics where [Resident #1] received steroid injections into his knees . During a telephone interview on 2/10/2026 at 9:58 AM, Resident #1's responsible party stated the facility had transported the resident for an appointment where Resident #1 .had shots in knees . without notifying the resident's responsible party of the outpatient appointments. The resident's responsible party stated this had happened twice (failure to notify family of the outpatient provider appointments). During an interview on 2/11/2026 at 3:46 PM, Transportation Technician A in presence of the [NAME] President (VP) for Clinical Services, stated she had transported Resident #1 to 2 orthopedic appointments for knee injections on 6/26/2025 and 12/4/2025. Transportation Technician A confirmed she had not notified Resident #1's responsible party of the resident's orthopedic appointments for 6/26/2025 and 12/4/2025. During an interview on 2/12/2026 at 10:00 AM, the VP for Clinical Services confirmed the transportation technician was expected to notify the resident's responsible party of appointments to include type of appointment, location, date, and time of appointment .to give the family the opportunity to meet the resident at the appointment or to transport the resident themselves .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to obtain a physician's order for the use of a seatbelt, failed to perform an assessment for the use of a seatbelt, and failed to identify medical symptoms that would require the use of a seatbelt for 1 resident (Resident #13) of 1 resident reviewed for physical restraints. The findings include: Review of the facility's undated policy titled, Restraint Free Environment Guidelines, revealed .The facility .limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints .A physician's order alone is not sufficient to warrant the use of a physical restraint. The facility is responsible for the appropriateness of the determination to use a restraint .Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of restraints, and determine .How the use of restraints would treat the medical symptom .The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint, and the time and frequency that the restraint will be released .Medical symptoms warranting the use of restraints should be documented in the resident's medical record . Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Spastic Quadriplegic Cerebral Palsy, Lennox-Gastaut Syndrome (rare form of early childhood epilepsy characterized by multiple daily seizures), Adult Failure to Thrive, Gastrostomy Status, Epileptic Seizures, and Unspecified Convulsions. Review of the comprehensive care plan initiated on 9/19/2024, revealed .limited physical mobility r/t [related to] cerebral palsy .prefers to sit in Indian style and rock back and forth . Review of the comprehensive care plan initiated on 9/20/2024, revealed .resident has a seizure disorder as well as Lennox Gastaut Syndrome. At risk for intractable seizures, seizures that can change over time, injury related seizures . Continued review revealed .at risk for falls r/t involuntary and uncoordinated movements, frequently sits cross legged on bed and rocks back and forth, poor trunk strength, seizures, poor safety awareness, potential side effects of medications . Further review revealed .ADL [Activities of Daily Living] self-care performance deficit related to cerebral palsy, seizure disorder. Unable to identify or verbalize wants or needs. All needs must be anticipated and met by staff . Review of the comprehensive care plan initiated on 10/1/2024, revealed .alert but unable to understand/comprehend what is being said to him .does not follow directions and is nonverbal . Review of a physician's order dated 4/30/2025, .enhanced supervision by staff. placed 1 to 1 [1 staff member to 1 resident] .every shift for safety . Review of the comprehensive care plan revised on 8/11/2025, revealed .seat belt/harness to wheelchair due to very poor trunk control . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 had no speech and was rarely/never able to make himself understood and rarely/never understood others. Resident #13 had severely impaired cognitive skills for daily decision making. Resident #13 had functional limitation in range of motion on both sides of the upper and lower extremities and required a wheelchair for mobility. Resident #13 was dependent on staff for all Activities of Daily Living (ADL) care. Continued review revealed physical restraints were defined as .any manual method or physical or mechanical device, material or equipment attached to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body . Resident #13's Physical Restraint portion of the MDS assessment stated Physical Restraints were .Not used .in chair or Out of Bed . Review of the medical record revealed a physician's order for the seatbelt had not been obtained and no documentation a restraint assessment had been completed for Resident #13's seatbelt. During an observation and interview on 2/9/2026 at 3:12 PM, Resident #13 was seated in a positioning wheelchair with a seatbelt across the waist and visiting with family. Resident #13's responsible party stated Resident #13 had seizures and the seatbelt was used for safety to keep the resident in the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	chair during seizures. Resident #13 had contractures to upper and lower extremities. Resident #13's responsible party stated the resident was unable to release the seatbelt on his own and it helped to restrict body movements. During an interview on 2/9/2026 at 3:32 PM, Licensed Practical Nurse (LPN) A stated Resident #13 was on 1 to 1 observation due to seizure precautions. Resident #13 used a seatbelt when out of bed in the chair .in case he has a seizure so he doesn't fall out of the chair . LPN A stated the seatbelt was not considered a restraint and confirmed Resident #13 was unable to release the seatbelt on his own. LPN A further stated she was not aware if a restraint assessment had been completed due to the seatbelt not being considered a restraint. During an observation and interview on 2/10/2026 at 4:14 PM, Resident #13 was seated in his positioning wheelchair with the seatbelt on. There was a 1 to 1 sitter at Resident #13's bedside. Sitter A stated a seatbelt was used when Resident #13 was in the wheelchair for safety due to his seizures. Sitter A was only responsible for notifying staff when Resident #13 had a seizure and for documenting the length of the seizure and did not provide direct care. During an interview on 2/11/2026 at 8:44 AM, the MDS Coordinator stated Resident #13 used a seatbelt while up in the wheelchair due to poor trunk control. The MDS Coordinator was unaware when Resident #13 began using the seatbelt in the wheelchair and confirmed there was no order for the seatbelt. The MDS Coordinator confirmed the seatbelt was a restraint by definition and stated .I was not aware he was using that until recently . The MDS Coordinator was made aware of restraints by physician's orders and during her visual observation conducted for the MDS assessment. The MDS Coordinator stated on an unknown date she observed Resident #13 up in his wheelchair and . I noticed it [seatbelt] .went and asked about it [unaware of date or who she asked] .was told yes he is using it [seatbelt] . The MDS Coordinator stated the Resident Assessment Instrument (RAI) was used to code MDS assessments. During an interview on 2/11/2026 at 2:11 PM, the DON stated Resident #13 had been using a seatbelt in his wheelchair since he was admitted to the facility and was used at home prior to admission. The DON confirmed the seatbelt met the definition of a restraint because Resident #13 was unable to remove it on his own. The Interdisciplinary Team (IDT) team met today (2/11/2026), regarding the use of the seatbelt and the DON discussed the seatbelt with Resident #13's responsible party explaining that the seatbelt met the regulation's definition of a restraint. The DON confirmed an order for the seatbelt had not been obtained until today (2/11/2026) and the seatbelt had not been assessed by the facility as a restraint. The DON confirmed an order for the seatbelt should have been obtained prior to the seatbelt being initiated and a restraint assessment performed. During an interview on 2/11/2026 at 3:20 PM, LPN B stated Resident #13 had a 1 to 1 sitter for seizures. Resident #13 had seizures daily. Resident #13 had a seatbelt when up in the wheelchair to keep him in the chair in the event of a seizure. LPN B stated there was no monitoring, set times for checking and releasing the seatbelt, or any documentation required when the resident was in the seatbelt. LPN B stated the seatbelt was not considered a restraint because it was for safety. LPN confirmed Resident #13 was unable to release the seatbelt on his own.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview the facility failed to provide a rationale for the continued use of an as needed (PRN) antianxiety medication beyond 14 days for 1 resident (Resident #19) of 5 residents reviewed for unnecessary medications. The findings include: Review of the facility's undated policy titled, Psychotropic Medication Use Guidelines, revealed .PRN orders all psychotropic drugs shall be used only when the medication is necessary to treat a diagnosed specific condition that is documented in the clinical record, and for a limited duration (i.e. [that is] 14 days) .If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she shall document their rationale in the resident's medical record and indicate the duration for the PRN order . Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Unspecified Psychosis, Depression, and Anxiety. Review of a comprehensive care plan dated 6/19/2025, revealed .Potential for mood state issues related to anxiety .administer medication as ordered . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #19 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Resident #19 had an active diagnosis of Anxiety Disorder and received Antianxiety medications. Review of a Psychiatric Periodic Evaluation dated 1/13/2026, revealed .Chief Complaint/Nature of Presenting Problem .anxiety .mood .tolerated change to klonopin [Clonazepam] [ClonazePAM] [a psychotropic medication used to treat anxiety] with improved anxiety. Continues having anxiety especially mid afternoon .Recommendations .Klonopin [ClonazePAM] 0.5 mg [milligram] .qdprn [every day as needed] anxiety x [times] 14 days . Review of a physician's order dated 1/13/2026, revealed .ClonazePAM [Klonopin] 0.5 MG [milligrams] .by mouth as needed for anxiety for 60 days .Once daily as needed . The order was entered by the provider (the same provider who conducted the Psychiatric Periodic Evaluation) for 60 days and not the 14 days as noted on the Psychiatric Evaluation. Review of a Medication Administration Record (MAR) dated 1/1/2026 - 1/31/2026, revealed an order dated 1/13/2026 for .ClonazePAM 0.5 MG .Give 1 tablet by mouth as needed for anxiety for 60 Days [the evaluation noted 14 days and entered as 60 days] Once daily as needed .Start Date .01/13/2026 . Review of a Psychiatric Periodic Evaluation dated 2/3/2026 (21 days after the PRN Clonazepam was ordered), revealed .Chief Complaint/Nature of Presenting Problem .anxiety .mood .delusions .Evaluating psychiatric medications for effectiveness and side effects .appears to be tolerating current medications well at this time .Evaluating mood and behaviors .Current Psychiatric Medications .Klonopin 0.5 mg TID and qd PRN .Recommendations .Continue the following medications .Klonopin 0.5 mg three times daily and qdprn anxiety x 14 days . Continued review revealed no rationale documented for the PRN dose of Clonazepam to be continued beyond the 14 days. Review of a MAR dated 2/1/2026 - 2/11/2026, revealed an order dated 1/13/2026 for .ClonazePAM .0.5 MG .Give 1 tablet by mouth as needed for anxiety for 60 Days [the evaluation noted 14 days, was not corrected and continued for the 60 days] Once daily as needed .Start Date .01/13/2026 . During an interview on 2/12/2026 at 10:26 AM, the [NAME] President (VP) of Clinical Services stated a PRN psychotropic medication was to be ordered for 14 days and a justification note should be entered in the resident's chart if the order was extended beyond 14 days. The Psychiatric Periodic Evaluation note dated 1/13/2026 revealed Resident #19 was to receive Clonazepam 0.5 mg daily PRN anxiety for 14 days. The psychiatric provider entered the order on 1/13/2026 for 60 days (and not the 14 days). The VP of Clinical Services stated the provider entered the order duration in error. Attempted telephone interview with the Psychiatric Nurse Practitioner (NP) on 2/12/2026 at 11:11 AM with no response. During an interview on 2/12/2026 at 1:22 PM, the Director of Nursing (DON) stated the facility had a clinical meeting daily Monday through Friday (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attended by the Interdisciplinary Team (IDT) and medication changes and new orders were reviewed by the IDT. The DON confirmed Resident #19 had a new order for Clonazepam 0.5 mg by mouth daily as needed for anxiety on 1/13/2026 for 60 days. The DON confirmed PRN orders for Psychotropic medications were to be only for 14 days and a rationale was required to extend on a PRN basis beyond 14 days and confirmed a rationale was documented for the PRN medication to be continued beyond the 14 days.

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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** Based on facility policy review, medical record review, and interviews, the facility failed to obtain a physician's order and assess a resident's ability to perform tracheostomy (surgical opening into the windpipe) self-care for 1 resident (Resident #2) of 1 resident reviewed for tracheostomy.The findings include: Review of the facility's undated policy titled, Care Services and Resident Choices & [and] Preferences, revealed .As appropriate, the residents will be involved in .the implementation of interventions and administration of care .While allowing residents to exercise his/her autonomy, the facility is responsible to determine if the residents' choice presents a risk or safety challenge to the resident .It is the resident's right to determine what, if anything, they would prefer to do or not to do each day in accordance with physician orders and resident's abilities . Review of the facility's undated policy titled, Tracheostomy Care Guidelines, revealed .The facility will ensure that residents who need respiratory care, including tracheostomy care and tracheal suctioning, is provided such care consistent with professional standards of practice .The facility, in collaboration with the attending practitioner, must perform a comprehensive assessment of the resident's respiratory needs .Tracheostomy care will be provided according to the physician's orders, comprehensive and individualized care plan . Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Tracheostomy. Review of a Nursing Admission/readmission Nursing Evaluation for Resident #2 dated 2/3/2026, revealed the resident was alert and oriented to person, place, time, and situation. Continued review revealed the resident had a tracheostomy. Review of a physician order for Resident #2 dated 2/4/2026 revealed .Change inner cannula [a removable, tube-shaped liner that fits inside the main outer tracheostomy tube] daily & [and] PRN [as needed] every shift for trach [tracheostomy] care .Trach Care done Q [every] 12 hours and PRN using Sterile Technique every shift . Continued review revealed no order for the resident self-care of the tracheostomy. Review of the medical record for Resident #2 revealed no documentation to show the resident had been assessed for his ability to change the inner cannula or perform his own tracheostomy care. During an observation on 2/9/2026 at 11:30 AM, revealed Resident #2 had a tracheostomy. During an interview on 2/10/2026 at 3:12 PM, Licensed Practical Nurse (LPN) A stated Resident #2 performed his own tracheostomy care. LPN A stated she had not observed Resident #2 perform his tracheostomy care. During an interview on 2/11/2026 at 8:00 AM, Resident #2 stated he changed his tracheostomy inner cannula and provided his own tracheostomy care while in the facility. During an interview on 2/11/2026 at 8:45 AM, LPN B stated Resident #2 performed his own tracheostomy care. During medical record review and interview on 2/11/2026 at 10:40 AM, the Director of Nursing (DON) confirmed there was not an order for Resident #2 to perform his own tracheostomy care and confirmed the resident had not been assessed to ensure he could perform his tracheostomy care appropriately using a sterile technique. During a telephone interview on 2/11/2026 at 1:20 PM, Resident #2's physician stated .I told nursing they have to monitor that it's being done and that it's being done properly .He is adamant about doing it and not entrusting it [tracheostomy care] to someone else .I don't know that I wrote that order for him to do his own trach care . During an interview on 2/12/2026 at 10:45 AM, the DON confirmed the order for Resident #2 to perform his own tracheostomy care was not added until 2/11/2026 (8 days after the resident was admitted to the facility and 2 days after the State Survey Agency survey began investigating).

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on facility policy review, facility documentation review, and interviews, the facility failed to employ a qualified social worker on a full-time basis.Review of the facility's undated policy titled, Social Services guidelines, revealed .A facility will employ a social worker on a full-time basis . Review of a facility typed document dated 2/12/2026, signed by the Administrator revealed from 5/9/2025 to 5/27/2025, 6/10/2025 to 8/11/2025, 10/8/2025 to 11/26/2025, and from 1/5/2026 to current (2/12/2026) the facility did not employ a qualified social worker for approximately 167 days or 5.5 months out of 9 months reviewed. During an interview on 2/10/2026 at 8:15 AM, the Social Worker stated .I [Social Worker] started here [employed by the facility] in October .it was the 13th [10/13/2025] .I was concierge from October 13th thru January the 5th .now I am the Social Worker .no I don't have a social worker degree or training .I am helping out with the social worker stuff until they get [hire] a social worker . During an interview on 2/12/2026 at 12:30 PM, the Administrator confirmed the facility did not have a qualified social worker employed from 5/9/2025 to 5/27/2025, from 6/10/2025 to 8/11/2025, from 10/8/2025 to 11/26/2025, and from 1/5/2026 to current (2/12/2026).