STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445251	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Hills Post Acute	895 Powers Blvd Waverly, TN 37185

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 - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on policy review, medical record review, facility investigation review, Emergency Medical Services, Police Department Incident Narrative, and interview, the facility failed to ensure safety interventions were implemented and failed to ensure an environment free of accident hazards for 1 of 3 (Resident #4) sampled resident reviewed for accidents, resulting in significant injury and death to Resident #4 . On 1/9/2026, Resident #4, who was moderately cognitively impaired and required staff assistance with transfers, was found unresponsive by Certified Nursing Assistant (CNA) A and lying supine (lying on back with face upward) on the floor with the bed control cord stretched across her body and neck area and pinned under her back near her left shoulder. Resident #4's head and torso were partially under the bed, with the bed resting on the Resident's head and chest. The facility's failure to ensure care plan safety interventions to keep the bed in low position were followed, resulted in immediate jeopardy when Resident #4 sustained serious injury that resulted in death. 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) and Assistant Regional Director Clinical Nurse were notified of the Immediate Jeopardy on 4/13/2026 at 5:29 PM, in the Day Room. The facility was cited Immediate Jeopardy at F-689. The facility was cited at F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ began on 1/9/2026 and continued through 4/14/2026. The IJ was removed on 4/15/2026 when the facility implemented a corrective action plan. The corrective actions were validated by the surveyor on 4/15/2026. A partial extended survey was conducted from 4/14/2026 through 4/15/2026. The facility's noncompliance at F689 continues at a scope and severity of D for monitoring of 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, .Safety and Supervision of Resident, with a revision date of 7/2025, revealed .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility - wide priorities.Implementing interventions to reduce accident risks and hazards shall include the following.Communication specific interventions to all relevant staff.Providing training.Ensuring that interventions are implemented. 2. Review of the closed medical record revealed resident #4 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Peripheral Vascular Disease, Convulsions, Repeated Falls, Psychotic Disorder with Delusions, Dementia, Obsessive-Compulsive Behavior, and Anxiety. Review of the Care Plan revised on 5/2/2025, revealed .Convulsions .has a diagnosis of seizure disorder and is at risk for complications manifested by Falling .Monitor for change in level of consciousness .Monitor for seizure activity . revised on 5/7/2025.is at risk for falls.r/t [related to] unstable balance, decreased safety awareness.impaired decision making skills, lack of coordination.Keep bed in low position with brakes locked. Review of the Nurse's Note dated 8/29/2025 at 7:27 AM, revealed .Resident found laying [lying] on back in the floor beside residents [resident's] bed. Alert and oriented x [times]1. No visible injuries.resident back to bed with 2 person assist.bed at lowest position. Review of the Care (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Plan revealed the Care Plan was revised on 8/29/2025 to provide a fall mat to left side of bed. There was no documentation the Care Plan had been revised with safety interventions implemented to prevent falls from the bed. Review of the FALL RISK OBSERVATION/ASSESSTMENT dated 10/23/2025, revealed Resident #4 had a fall risk score of 16, which indicated the Resident was high risk for falls. Review of the Nurse's Note for Resident #4 dated 10/23/2025 at 4:53 PM, revealed .CNA notified nurse of fall. Resident found lying in floor beside bed. Assisted into sitting position. Laceration noted to LLE [left lower leg].resident to ER [Emergency Room] for further evaluation.EMTs [Emergency Medical Technicians] arrived to get patient. Review of the Nurse's Note for Resident #4 dated 10/23/2025 at 9:30 PM, revealed .Resident returned from the ER [emergency room].via [by way] stretcher. Returned with N.O. [new order] for Keflex [an antibiotic used to treat infections] 500 mg [milligram] 3x [3 times] a day for 5 days.remove sutures [from left lower leg] in 2 weeks. Review of the Care Plan revealed the Care plan was revised on 10/23/2025 for staff to provide incontinent care prior to meals. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the Resident was moderately cognitively impaired, dependent on staff for activities of daily living and had one fall with injury during the review period. Review of the medical record dated 1/6/2026 revealed Resident #4 weighed 210.8 pounds. Review of the facility's fall investigation dated 1/9/2026 at 4:55 AM, revealed .FALL.UNWITNESSED.Residents Room [Resident #4] .CNA alerted nurse.How was the Resident positioned when you observed them.on back on floor.What time did you last see the Resident before the occurrence.0340 AM [3:40 AM]. Review of the Nurse's Note for Resident #4 dated 1/9/2026 at 5:32 AM, revealed .CNA notified nurse of patient being on floor and appearing unresponsive. Nurse entered room and witnessed CNA providing chest compressions. Immediately assisted with CPR [Cardiopulmonary Resuscitation] while other nurse contacted 911. EMTs arrived and transported resident to ER. Review of the Witness Statement dated and signed by CNA A on 1/9/2026, revealed I was rounding on my patients for last round when I entered [Named Resident #4's] room .I found patient [Resident #4] laying [lying] on her back partially underneath the bed. The bed was in the lowest position with the cord to the controller [bed control] wrapped across her [Resident #4] neck and the end with the buttons was under back/shoulder area. I immediately pulled the remote from underneath her and elevated the entire bed so that it no longer pinned against the patient's chest. I ran out to the hallway to notify and get a nurse .the nurses from both stations and myself began CPR immediately until EMS arrived. I rounded on the hall and [Named Resident #4] was changed at 3:40-3:45 am [AM]. Patient was alive and fine in bed when I left her. The time that I found [Named Resident #4] was around 4:50-4:55ish [AM]. Review of the Witness Statement dated and signed by CNA B on 1/9/2026, revealed [Named CNA A] Came out of [Resident #4's room] .4:55 am [AM] .yelling where is the nurse I asked why he said Patient [Resident #4's room] was underneath bed with .the bed on top of her head and body I .Ran in the Room took the Cord Away from her head and bed off of her checked her pulse and started performing CPR until the nurse Came in. Review of the Emergency Medical Services (EMS) Prehospital Patient Care Report dated 1/9/2026, revealed EMS arrived at the facility at 5:04 AM, .cpr in progress .Staff relates they do not know how long pt [patient/Resident #4] was trapped/pinned by her bed. Staff relates the beds corded control remote was found wrapped around pt with the control buttons underneat. Staff relates they had to move pt to access the bed's control to raise the bed before they could get the bed raised off of pt and slide pt out from underneath the bed frame. Staff relates they found pt to be unresponsive, apneic [not breathing], and pulseless .they [facility staff] started CPR .Staff relates pt hx [history] of falls and dementia .Upon arrival . [Resident #4] [was found] laying supine [lying on back] on the floor next to a bed with CPR being performed .upon assessment with visibly cyanotic/blue coloration to her face and a mark across her chest possibly from the bed she was pinned beneath. Pt has no other visible signs of trauma noted at time of initial assessment .full Code [provide full resuscitation] .possibly secondary to traumatic asphyxiation .Pt (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	care taken over and CPR resumed by [EMS] .4th rhythm check performed finding pts rhythm Asystole [no heart rate]. With CPR performed prior to our arrival and multiple rounds of CPR with ACLS [Advanced Cardiovascular Life Support provides advanced techniques for critical care providers to stabilize patients after cardiac arrest] drugs given with no change in pt vitals or rhythm, on line medical control was contacted by phone at [Named local hospital] to discontinue resuscitation efforts. ED [Emergency Department] MD [Medical Doctor] on duty relayed orders to discontinue efforts .MD .local medical examiner performed a brief exam and gave time of death 0530 [5:30 AM] .deceased transported to .[Named] county morgue . Review of the Police Department Incident Narrative by the responding Officer revealed, .On 01-09-2026 approximately 0500 hours [5:00 AM] I, Officer .was dispatched [Named Long Term Care Facility] .I arrived on scene at 0503 [5:03 AM] .Upon entering room [Resident #4's room] .I observed a .female laying on her back in the floor .Two Nursing Home staff members were performing CPR .0505 [5:00 AM] .EMS .arrived .and took over CPR .at which time I left the room to speak with staff .I made contact with [Named CNA A] .he stated found [Named Resident #4] around 04:40-04:45 [AM] hours. He stated she was trapped by the bed and all of her upper body was underneath the bed .stated he raised the remotely control [controlled] bed off of the victim [Resident #4] and then ran and located a nurse to help him with the victim .He went on to state he and the nurse pulled the Victim from underneath the bed and immediately started CPR while someone else place a call to 911 .[Named CNA A] later said the victim had the remote for the bed under her body. He stated he pulled the remote out from under her while getting the Victim pulled from underneath the bed. He stated the cord on the remote was laying across her chest and over the left shoulder with the controller under her back. He did state the cord was not wrapped around her neck but only laid against her neck. After EMS cleared the room I .inspected the body .and did observe bruising and compression marks on her lower torso and between her breast consistent with the underpinning of the mechanical bed. The victim also had a compression mark on the left side of her face in the same direction as the marks on her lower torso . Review of the Police Department Incident Narrative by the Detective revealed, .On 01-09-2026 at approximately 0550 [5:50 AM] hours I, Detective.received a call.in reference to a deceased person at [Named Long Term Care Facility].upon arrival I spoke to [the] Officer.stated he arrived on scene to find [Named Resident #4] deceased , lying in the floor of her room.While examining the body.I noticed multiple marks across her [Resident #4's] chest and face consistent with the frame of the bed. The marks began on her stomach and went up across her chest and across the left side of her face. These marks appeared to be the same size and shape of the frame of the bed. There was [were] also smaller marks on her chest that appeared to be the same size and shape of the piston on the bed used for raising and lowering it. I noticed a chunk of hair lodged in the bolt of the bed on the lower frame where [Named Resident #4] was stated to have been found. It appeared that [Named Resident #4] attempted to get out of bed or fell out of bed and in doing so knocked the bed remote under the bed and fell on it. This caused the bed to lower onto her chest and head. While examining the bed and room I also noticed there was a fall alert system attached to the bed rail. Upon examining the alert system I noticed it was not plugged in to anything and was not set up to make any type of alerts if [Named Resident #4] were to get out of bed or fall. I also noticed the call button.was tucked behind her nightstand and would not have been accessible for her to call the nurse's station. I did pull the call button from behind the nightstand and pushed the button.a staff member reported to [the] room.in response to the call. This confirmed to me that the call button did work. While speaking to her [staff member] about the call button I inquired about the fall alert system on the bed. She [staff member] told me [she] would have to go and check to see if [Named Resident #4] was still using that or not. She reported back and told me that according to [Named Resident #4's] chart she no longer needed the fall alert system. I later spoke to multiple staff members who stated [Named Resident #4] was unable to walk on her own and was constantly falling.Staff members told me that due to [Named Resident #4's] dementia she would often times holler for help even when nothing was wrong . Review of the facility's Physician (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Discharge summary dated [DATE], revealed .Date of discharge 1/9/2026.Resident was initially admitted in April of 2021.She has declined physically throughout stay and mentally. Bedbound with severe psychiatric issues. During a telephone interview on 4/8/2026 at 2:56 PM, CNA A was asked about the incident regarding Resident #4 on 1/9/2026. CNA A stated, .she was pinned underneath her bed.remote was pinned underneath her.it was evident she had already passed away.the moment I open the door.I knew she was gone.she had the indentures on her face.of the actually [actual] bedframe on her face.I went to go get help. CNA A stated he had not initiated CPR and stated, . went to get help.I think [Named Licensed Practical Nurse (LPN) D] started CPR. During a telephone interview on 4/8/2026 at 3:22 PM, Registered Nurse (RN) H stated, .when I arrived in the room [Resident #4's room].the contract CNA [referring to CNA B] she was pushing the bed to the side.and patient [Resident #4] was laying out on the floor.it was very obvious that she [Resident #4] had not been passed long.still soft.warm around neck.cool face and lips.she wasn't my patient.I could walk down the hall and hear her call out till she went to sleep.that's the only interaction that I had. During a telephone interview on 4/8/2026 at 3:09 PM, LPN D stated, .she [referring to CNA B] was the only one performing CPR.but there was another CNA [referring to CNA A] in the room at the time.when I came in the room.I could tell she [Resident #4] was gone.she was warmish cold.she hadn't been gone very long.she felt like she had been uncovered from a blanket.from the time I had worked there.she couldn't get up and walk if she wanted to.she had been on therapy.at least one incident.she had surgery on her leg where she had attempted to get out of bed.it wasn't a regular occurrence for her to try to get out of bed.the way it [the incident] happened it was messed up.you could see the indentures [of the bed frame] on her. During an interview on 4/13/2026 at 9:05 AM, the Director of Nursing (DON) stated Resident #4's fall care plan included the current interventions of bed in the lowest position and fall mat on her left side. During an interview on 4/13/2026 at 9:08 AM, the MDS Coordinator was shown Resident #4's care plan for falls and was asked if she developed the care plan. The MDS Coordinator stated, I did. The MDS Coordinator was asked what interventions were in place for falls. The MDS Coordinator stated, .fall mat to left side of bed.keep bed in low position and brakes locked.call light within reach. The MDS Coordinator confirmed Resident #4 could not walk or turn herself side to side in bed without staff assistance. During an interview on 4/13/2026 at 10:03 AM, the Occupational Therapist (OT) stated, I was very sad and distraught when I heard she [Resident #4] left us.last time she received therapy was September 2025.from 9/3- 9/30 [2025].she had just got a new wheelchair.custom seating.tilt and space.had a fall. The OT stated Resident #4 was not mobile and stated, .she was two person assist.we always recommended two person assist. The OT stated that when she would see Resident #4, the Resident's bed would be in low position. The OT was asked how Resident #4 had progressed in therapy. The OT stated,.often our therapy was to teach care givers.usually in training teach the CNA's to raise the bed while doing their care.they did implement at one point fall mat.on the side of her bed just because she was a risk.she had long history of decline. The OT was asked if Resident #4 was totally dependent on staff for bed position and care. The OT stated, Yes. The OT was asked did you ever see Resident #4 have a seizure. The OT stated, I have not .I knew it was in her records.she had functioning of alertness.somedays she would talk out and other days she was asleep.if she was in need of care.she would say please God please.there were times she would sing hymns. The OT stated she never saw Resident #4 use her call light or bed remote and the Resident lacked the physical ability to pull herself up from the floor into a sitting position. The OT stated, .I'm not for sure what happened.I was surprised.you go through your whole career.it's distressing.I just know it was an unfortunate event. During a telephone interview on 4/13/2026 at 11:27 AM, CNA B stated, It was [a] horrible sight.took care of her [Resident #4] plenty of times. CNA B was asked was Resident #4 totally dependent on staff for bed position and care. CNA B stated, Yes ma'am, no way she could walk. CNA B was asked did you ever see Resident #4 have a seizure. CNA B stated, I have never seen her have seizure. CNA B was asked did you see a fall mat beside the Resident's bed. CNA B stated, I didn't. CNA B was asked what a low position bed means. (continued on next page)

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CNA B stated, .I raised the bed.and I took the cord [from] around her [Resident #4] neck.and I pulled her away from the bed.he [referring to CNA A] was screaming and hollering.saying where is the nurses.and I was thinking why didn't he pull her away from here.I don't understand why he [CNA A] left the bed on top of her.[the bed] was still on her.and the cord was around her neck. CNA B was asked had CNA A raised the bed off her. CNA B stated, No ma'am.it was like the bed was a tattoo on her. CNA B was asked did she [Resident #4] have a fall mat. CNA B stated, I didn't see a fall mat.she was on the left side [referring to the left side of the bed]. CNA B confirmed she had initiated CPR and stated, .it was horrible.I was sitting at the front desk.he [CNA A] come running out of the room.and he said the bed is on her [Resident #4].he showed me the room.I told him to go get them [referring to the nurses].I started chest compression.they came in a few minutes.I stopped CPR when the nurse came in.and took over.EMS.didn't get a pulse at all.[Resident #4] started to feel cold a little bit.and starting to turn blue.she [Resident #4] never calls you.I have never seen her use the call light.I don't think it [referring to the bed position] was to the floor [in the lowest position]. During an interview on 4/13/2026 at 12:12 PM, LPN E was asked was Resident #4 able to walk. LPN E stated, No, she couldn't walk.she thought she could so when she would get out of bed.she would fall. LPN E was asked was she [Resident #4] totally dependent on staff for bed position and care. LPN E stated, Yes. LPN E was asked was she a two person assist. LPN E stated, .at the end 2 [used to be a one person assist but was presently a 2-person assist] . LPN E was asked what position was Resident #4's bed supposed to be in. LPN E stated, The lowest position because she was a fall risk. LPN E was asked was Resident #4 able to use the bed remote and call light. LPN E stated, No.she would holler at night.please Lord please.say it two or three times. LPN E was asked if the Resident's bed had been in low position, could that have made a difference for the Resident being unable to get under the bed. LPN E stated, .if it was on the lowest position don't see how she could get under it.they go all the way down so if they fall they don't get hurt as bad. During a telephone interview on 4/13/2026 at 12:39 PM, CNA A was asked could Resident #4 walk. CNA A stated, No.she couldn't.I have seen her trying to get out of bed.get her feet out and one time seen her have both legs off the bed.and I readjusted her, didn't have any more trouble. CNA A was asked was the Resident totally dependent on staff for bed position and care. CNA #1 stated, Yes, I believe so. CNA A was asked if he had ever seen Resident #4 use the call light or bed remote. CNA A stated, I want to say she used her call light.but not her bed remote. CNA A was asked what position was the Resident's bed in the last time he saw her at 3:40 AM. CNA #1 stated, .I believe it was waist high.that's typically where it's at all the time. CNA A was asked did you see a fall mat beside the Resident's bed. CNA stated, No, she didn't have one. During an interview on 4/13/2026 at 1:08 PM, the Administrator verified that he was the Administrator in training on 1/9/2026. The Administrator was asked who notified you about Resident #4's incident on 1/9/2026. The Administrator stated, .[Named the Previous Administrator]. The Administrator was asked what the facility decided was the cause of Resident #4 ending up pinned underneath the bed. The Administrator stated, .while I was training.I was limited to understanding.I was involved to an extent.there are topics that I was not fully involved in.can't say for certain what was included or how she made her way under [the bed]. The Administrator was asked why was this not given to the surveyor when the facility was asked for any usual investigation or anything about a death that had been investigated. The Administrator stated, When you first came in, I wasn't sure of the time frame.I came in the end of January.when you said unusual thought it was the time I was here.even for this it's a freak accident.thought everything had been verified for the story.I thought the investigation was complete.and there was reasonable explanation.I can't tell you the explanation. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	During an interview on 4/13/2026 at 1:34 PM, CNA C confirmed she was Resident #4's restorative aide and stated, .her [Resident #4] upper body was more active than the lower body.when I first meet her 4 years ago she could walk.she had [a] full decline process.the last couple of weeks was using a [name of mechanical lift] lift to move. CNA C was asked was Resident #4 able to walk. CNA C stated, No. CNA C was asked was Resident #4 able to turn side to side. CNA C stated, No, we turned her.she did have a custom wheelchair.she could not self-propel her chair. CNA C was asked was the Resident totally dependent on staff for bed position and care. CNA C stated, Yes, she was.night shift would turn her at night and day shift would do the same if she wasn't in her chair. CNA C was asked did you ever see the Resident have a seizure. CNA C stated, Yes.when I worked the night shift.I know she had them.I would deal with her seizures at night.a year ago [last time this CNA recalled the Resident experiencing a seizure]. CNA C was asked what position the bed was in when she worked with Resident #4. CNA C stated, Low to the floor.I would never put her bed above my knee.I kept her bed in low position.you just never know. CNA C was asked would Resident #4 been able to get underneath the bed if it was positioned at knee height. CNA C stated, I wouldn't think so. CNA C stated she had worked with Resident #4 the day before the bed was found on top of Resident #4 and stated, .[Resident #4] was up in chair and was in my office. We were sorting building blocks.could feed herself finger foods. CNA C was asked was Resident #4 able to use the bed remote and call light. CNA C stated, She could but she was notorious for yelling.would tell you what she needed if you asked her.she was alert and oriented to herself. During an interview on 4/13/2026 at 3:13 PM, the DON was asked who had informed her about Resident #4 on 1/9/2026. The DON stated, [Named LPN F].told me they were doing CPR.had found [Named Resident #4] underneath her bed unresponsive.and had called 911.had her repeat it to me again.and she repeated it to me again.told her to continue with her [Resident #4] and I am going to reach out to [Named previous Administrator].called and woke him up.we came up.when I got here [Named Medical Examiner] was up here.investigator.two or 3 cops [at the facility].and [Named Quality Assurance (QA) Nurse].was here.I had called her [QA Nurse].once we got here.we talked to [Named Medical Examiner] he told us what he observed, the marks on her [Resident #4] chest and abdomen.he wasn't here long.had all staff still here.talked to the investigator.we interviewed everybody that was here.they wrote statements.[Named CNA A and CNA B].we called them back due to the discrepancy [referring to who had removed the bed remote to raise the bed and who started the CPR].one that said he started and the other said she started it. The DON confirmed both CNAs were agency staff. The DON was asked what they had determined as to how Resident #4 got underneath the bed. The DON stated, We were trying to figure it out.when she started moving around, the remote had to come down with her.looked like it went across her left shoulder.and as far if the bed was down like it was supposed to be and if she wiggled, moving her upper body around.depending on the location of the button.did it raise it up and then bring it down.when it [the bed] got on top of her [Resident #4] it continued to press down on her. The DON confirmed the bed should have been all the way down to the floor and stated, Everything we were told it [the bed] was not up in the air [in a high position] . The DON confirmed she had never seen Resident #4 have a seizure and stated, .we tossed that idea [referring to the Resident having a seizure] and wonder if that was the cause.when I came in 2024.she wasn't walking anymore.she could tell you what she wanted.so many thoughts came into my head.why didn't she [Resident #4] yell.said she was yelling around 2 [referring to 1/9/2026 at 2:00 AM].he [CNA A] changed her and she quit yelling.between 3 and 4 [3:00 AM and 4:00 AM] checked on her. The DON was asked was Resident #4 having to be checked more frequent since it was just 1 hour since the CNA had last check on her. The DON stated, .he was just walking down the hall doing a spot check and that's when he saw her. During a telephone interview on 4/14/2026 at 10:32 AM, the Detective stated, .I remember the call light being tucked behind the nightstand and [Resident #4] couldn't reach. During a telephone interview on 4/14/2026 at 2:14 PM, the Previous Administrator was asked what happened on 1/9/2026 with Resident #4. The Previous Administrator stated, .I got a call around 5 am [5:00 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445251	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waverly Hills Post Acute	895 Powers Blvd Waverly, TN 37185

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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 Note: The nursing home is disputing this citation.	AM].DON.told me had been incident and that they had called EMS.I got ready came on in.they had already left with her [Resident #4], by the time I got here they [referring to EMS] had already left.[Named the Medical Examiner] was here.he basically told me that he would do his report.sent off autopsy and he did say that would take a long time.he indicated there were no foul play.no concerns just a horrible accident.and then also meet with the police investigator and told me basically the same thing.he indicated the same .he didn't have any concerns of foul play.appeared to be an accident.from there we dove into the investigation.pulled everyone in got witness statements from everyone involved. The Previous Administrator was asked do you know when Resident #4 last had a seizure. The Previous Administrator stated, I do not. The Previous Administrator was asked what the root cause of the Resident's fall was. The Previous Administrator stated, .she [Resident #4] worked herself out of the bed.rolled tried to crawl.ended up out bed on her own.behavior related . The Previous Administrator was asked if the Resident's bed had been in the lowest position could the Resident had gotten underneath the bed. The Previous Administrator stated, .through our investigation the statements and conversation we had don't remember that being an issue. The Previous Administrator was asked if he had reported this unusual incident to any state agencies and stated, .didn't report to any department [State Survey Agency]. The Previous Administrator was asked about the discrepancies related to CNA A and CNA B's statements. The Previous Administrator stated, .we called them both back in.we determined that either statement was accurate.he [referring to CNA A] had done a little bit of the moving [referring to moving of the bed partially off Resident #4]. During a telephone interview on 4/15/2026 at 11:12 AM, the Physician said he provided care to Resident #4 and stated, .something like that [Resident #4 being pinned underneath her bed and dying as a result], I was shocked.she [Resident #4] was mainly bed ridden.police were involved.she [Resident #4] was paranoid.she had been my patient for years. The Physician was asked when the last time was you saw Resident #4. The Physician stated .I went every month.She had declined.when she first got there, she was mobile.then wheelchair [dependent].you could see the steady decline. The Physician was asked do you know when she had her last seizure. The Physician stated, .a couple of years.she had [a] diagnosis of Alzheimer's.she had quite a few behaviors. The Physician was asked should staff follow care plan interventions. The Physician stated, Yes. The Physician was asked if Resident #4's bed had been in the low position as care planned could the Resident have gotten underneath the bed. The Physician stated, .that would be hard.usually there is a mat.it would be difficult for her to get under the bed.she would yell out.I'm not g