STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445252	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Centerville	112 Old Dickson Rd Centerville, TN 37033

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, observation, and interview, the facility failed to report allegations of abuse to State Agency, Ombudsman, Adult Protective Services, and Law Enforcement for 4 of 4 (Resident #48, #54, #58, and #59) sampled residents reviewed for allegations of abuse. The findings include: 1. Review of the facility's policy titled, Abuse-Protection of Residents dated 6/17/2024, revealed The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation .methods to ensure the protection of residents during an investigation may include but not limited to Responding immediately to protect the alleged victim and integrity of the investigation .Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed .Immediate notification of the alleged victim's practitioner and the family or responsible party Removal of access by the alleged perpetrator to the alleged victim and that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents Notification of the alleged violation to other agencies or law enforcement authorities Evaluation of whether the alleged victim feels safe and if the he/she does not feel safe, taking immediate steps to alleviate the fear, such as room relocation, increased supervision .Monitor the alleged victim and other residents at risk . Review of the facility's policy titled, Abuse-Identification of Types dated 6/17/2024, revealed Sexual abuse a non-consensual sexual contact of any type with a resident Facility staff should report any suspected abuse, neglect, or exploitation Sexual abuse is non-consensual sexual contact of any type with a resident, as defined at have the capacity to consent sexual contact is nonconsensual if the resident Appears to want the contact to occur but lacks the cognitive ability to consent . (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse-Conducting an Investigation dated 6/17/2024, revealed It is the policy of this facility that allegations of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated. The facility will prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress; and take appropriate corrective action as a result of the investigation findings. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported Following identification of alleged abuse, the resident (s) receive prompt medical attention as necessary and the resident are protected during the investigation to prevent recurrence The alleged victim will be examined for any sign of injury, including a physical examination or psychosocial assessment .When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence the investigation would include but is not limited to Conducting observations of alleged victims .Conducting interviews with .the alleged victim and representative, alleged perpetrator, witnesses, practitioner Conducting record review for pertinent information related to the alleged violation such as progress notes The written summary of the investigation should include but not limited to A review of the Incident Report .An Interview with the person(s) reporting the incident Interviews with any witnesses to the incident An interview with the resident, if appropriate .a review of the resident's medical record .an interview with the employee(s) .a review of the employee's file Interviews with staff members on all shifts having contact with the resident at the time of the incident Interviews other residents who received care or services from the alleged perpetrator A review all circumstances surrounding the incident If the accused individual is an employee, the alleged perpetrator will be removed from resident care areas immediately and placed on suspension pending results of the investigation. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited If the accused abuser is another resident, the resident must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents .Any investigation of alleged resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent .The administrator or their designee will keep the resident and/or his/her representative informed of the progress of the investigation. The alleged victim will be protected from retaliation .The administrator or designee will inform the resident, physician, and/or resident representative of the results of the investigation and the corrective action taken. Emotional support and counseling will be provided to the resident during and after the investigation, as needed . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse-Reporting and Response-No Crime Suspected dated 6/17/2024, revealed Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care facilities) All associates are mandated to immediately report suspected resident abuse and /or neglect to their immediate supervisor and/or facility representative All residents, families, resident representatives and visitors are encouraged to immediately report incidents of suspected resident abuse and/or neglect to facility administration. When an incident of resident abuse is suspected, the incident must be reported to the supervisor regardless of the time lapse since the incident occurred. The supervisor notifies the director of nursing and the executive director of the alleged incident .All alleged violations .must be reported to the administrator of the facility and to other officials in accordance with State Law through established procedures .the facility should retain documentation of the report The supervisor and /or charge nurse will illicit the following information .the name of the resident involved in the incident .date and time the incident occurred where the incident took place name(s) of the person(s) committing or involved in the incident name(s) of any witnesses to the incident type of abuse and /or neglect that was committed .additional information that may be pertinent to the incident the nurse will complete and sign the Incident Report and notify the physician and the resident's representative of the occurrence . Review of the facility's policy titled, Incident and Reportable Event Management dated 9/14/2023, revealed Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) Event Management includes, but is not limited to , the following types of events . Alleged Abuse .Sexual, Physical, Verbal, Mental, or Exploitation 2. Review of the medical record revealed Resident #48 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, Heart Failure, Alzheimer's Disease, and Depression. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 12, indicating Resident #48 was moderately cognitively impaired, dependent on staff with assistance in toileting and required max assistance from staff with performing transfers and incontinent both bowel and bladder. Review of the Care plan dated 9/3/2024, revealed .The resident has episodes of urinary and bowel incontinence .Assist with toileting as needed. BM [Bowel Movement] protocol as ordered PRN [as needed] . Peri-care as needed . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Social Services Note dated 9/10/2024, revealed ED [Executive Director] and SS [Social Services] met with resident regarding her CNA [Certified Nurse Aide] complaint. Resident was upset with CNA because of her tone, feeling that CNA tells her what to do. Resident said she likes her CNA and does not want her to be removed from her care. CNA spoken to. SS [Social Services] will follow up with resident. During an observation and interview in the resident's room on 9/10/2024 at 3:53 PM, Resident #48 stated that CNA D is hateful to her when she has a bowel movement in her brief. Resident reported that CNA D scolded resident for being incontinent of stool by stating that it is ridiculous, and that resident should have called for assistance to use bedpan or go to the bathroom. Resident stated that she reported the incident to Licensed Practical Nurse (LPN) B several weeks ago. During an interview on 9/11/2024 at 4:23 PM, the Administrator was asked if allegations of abuse are reported. The Administrator stated, Yes. The Administrator was asked if Resident #48's allegation of verbal/mental abuse should be reported. The Administrator stated, I did not think so . 3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Diabetes, Acute Cholecystitis, Muscle Weakness, Reduced Mobility, Dementia, Depression, Chronic Pain, Long Term Use of Anticoagulant, Obesity, and Abnormality of Gait and Mobility. Review of a facility's Behavior Note dated 3/13/2024, revealed, Resident noted to have inappropriate verbal behaviors towards female staff . Review of a facility's Health Status Note dated 5/15/2024, revealed, Resident then began making inappropriate comments to staff X [times] 2, Stating, Climb in bed so I can [expletive] on ya [you]. This nurse educated resident on not talking to staff in that manner, staff is here to help him, but not with those needs; Redirection was unsuccessful, again resident made profane comments to CNA Staff X 2 reminded resident that we are not here to be talked to that way Review of a facility's Behavior Note dated 6/7/2024, revealed, Resident noted this shift to be trying to kiss [Resident #58] another resident in hopes [Hopes Place (secure unit)], resident redirected and later separated r/t [related to] continuing with same behavior Review of the quarterly MDS dated [DATE], revealed Resident #54 has a BIMs of 3, which indicate the resident has cognitive impairment, required moderate to maximal assistance for Activities of Daily Living skills (ADLs), with active diagnoses of Non-Alzheimer's Dementia and the use of an antidepressant medication. Review of a facility's Behavior Note dated 8/14/2024, revealed, Resident noted to be kissing another female resident. Residents separated and staff doing 1:1 [one on one] with female resident Review of a Psychiatric Evaluation Note dated 8/19/2024 revealed .Staff did report that he was seen kissing a female resident on 8/14/2024 . Review of the Care Plan dated 8/20/2024 revealed Resident #54 was care planned for needing assistance for Activities of Daily Living (ADL) care and no care plan for behaviors. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility's Event Note dated 9/10/2024, revealed .DON [Director of Nursing] was made aware of alleged issue that occurred on 8/14/2024 between resident and male resident. Male resident was heard calling this resident over to him. This resident was then seen approaching resident and bent down. Nurse only seen back of resident's head at this time. Residents were then separated and 1:1 was provided until behaviors resolved. Local law enforcement, Ombudsman, Psych services, DON, ED, MD [Medical Director], RVP [Regional [NAME] President], RDCS [Regional Director of Clinical Services] and residents conservator . were all notified of alleged issues . The facility failed to provide documentation the State Agency, Adult Protective Services, Ombudsman, and family representatives were notified when Resident #54 attempted to kiss Resident #58 on 6/7/2024 and when Residents #54 and #58 were observed kissing on 8/14/2024. 4. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Depression, and Cognitive Communication Deficit. Review of the quarterly MDS dated [DATE], revealed Resident #58 was severely cognitive impaired and required moderate assistance from staff for ADL's care. Review of the Care plan revised 6/13/2024, revealed Resident #58 was dependent on staff for meeting emotion, intellectual, physical and social needs related to cognitive deficits, and had self-care performance deficits, at risk for elopement due to wandering, behavior problems or wandering and confusion due to diagnosis of dementia, impaired cognitive ability, impaired thought process due to dementia, impaired ability to understand others and impaired ability to make self understood, at risk for elopement due to wandering, and at risk for change in mood or behavior due to anxiety, depression, and dementia, and the use of antidepressants. Review of a facility's Event Note dated 9/10/2024, revealed DON was made aware of alleged issue that occurred on 8/14/2024 between resident and male resident. Male resident was heard calling this resident over to him. This resident was then seen approaching resident and bent down. Nurse only seen back of the residents [resident's] head at this time. Residents were then separated and 1:1 was provided until behaviors resolved. Local law enforcement, Ombudsman, Psych services, DON, ED, MD, RVP, RDCS, and residents [resident's] conservator .were all notified of alleged issues . The facility failed to provide documentation that State Agency, Adult Protective Services, Ombudsman, and family representatives were notified when Resident #54 attempted to kiss Resident #58 on 6/7/2024 and when Residents #54 and #58 were observed kissing on 8/14/2024. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an interview on 9/10/24 at 8:33 AM, LPN F confirmed she was the nurse assigned to the unit on 6/7/2024 and on 8/14/2024 when Resident #54 attempted to kiss a female resident and again when they were witnessed kissing on 8/14/2024. LPN F confirmed the female resident was Resident #58. LPN F confirmed that she reported the incident to the DON. LPN F was asked what was done after she reported the incident to the DON. LPN F stated that she tried to keep the residents separated as much as possible. LPN F stated she does not recall if she notified the family representatives at that time. LPN F stated the family representatives should have been notified at that time. LPN F confirmed she did not complete an incident report, and one should have been completed at the time of the incident. LPN F stated that Resident #54 has not had this type of behavior toward any other female residents but has said sexual inappropriate things to female therapy staff. LPN F stated these sexual inappropriate behaviors should not occur. LPN F was asked if she witnessed behaviors of sexual inappropriateness what should be done. LPN F stated that it should be reported to the DON, and they would talk about the it and decide what should be done. LPN F stated she was unsure what was done about the sexual inappropriateness, and they try to keep the residents separated as much as possible. LPN F was asked is Resident #54 and #58 have the cognition to give consent for a kiss. LPN F stated, I don ' t think so . LPN F was asked should this be reported as an allegation of abuse. LPN F stated, Yes. During an interview on 9/10/24 at 8:08 AM, the Administrator confirmed she was the Abuse Coordinator, and any allegation of abuse should be immediately reported to her, the DON, and Assistant Director of Nursing (ADON) in her absence. The Administrator confirmed when there is an allegation of abuse, statements from both staff and residents are obtained, the medical record is reviewed of the involved residents and an investigation is started. The Administrator was asked how if there was differentiated actions with sexual behaviors. The Administrator stated that if there is a sexual allegation, the resident would be sent to the hospital to be evaluated. The Administrator was asked it they were aware of the incident that occurred on 6/7/2024 when Resident #54 attempted to kiss Resident #58 and then again on 8/14/2024 when it was witnessed them kissing. The Administrator confirmed she was aware of the incident when the Resident was seen holding hands with a Resident but was not aware of the 6/7/2024 or the 8/14/2024 occurrence of the Residents kissing. The Administrator was asked what was discussed with the Resident with a BIMs of 3. The Administrator stated they try to redirect the Resident. The Administrator was asked who was called if the Resident with a BIMs of 3 was his own Power of Attorney. The Administrator stated, I will have to check to make sure who we called . The Administrator confirmed that the occurrence on 6/7/2024 was not reported to State Agency, the Ombudsman, or Adult Protective Services. The Administrator stated she was unsure if she was notified of the kissing which occurred on 8/14/2024 between Resident #54 and #58. The Administrator confirmed the kissing occurrence on 8/14/2024 should have been reported and investigated when it occurred. The Administrator was asked what the nurse should have done when she had been made aware of the kissing between the two Residents. The Administrator confirmed the nurse should have reported the allegation to her or the DON or any supervisor. The Administrator confirmed that the family should have been notified as well as the physician and psychiatric services. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/10/24 at 4:14 PM, the DON confirmed she was the Abuse Coordinator for the facility and any allegation should be reported to her. The DON stated that if in immediate danger the staff should provide safety and start an investigation and witness, resident and staff statements should be obtained, and it should be reported the State Agency, local law enforcement, and the family, as well as APS and the Ombudsman. The DON was asked how she determined if it was a behavior or sexual abuse. The DON stated by the Resident's BIMs score and if the Resident has a history and medical diagnoses. The DON was asked if residents with a BIMs of 2 or 3, which is severe cognitive impairment, were observed kissing, would that be a behavior or an allegation of sexual abuse. The DON stated, I would say that is a behavior . The DON was asked should that be reported as an allegation of sexual abuse. The DON stated, No because it is a behavior . The DON confirmed she was unaware of the incident on 6/7/2024 when Resident #54 was attempting to kiss Resident #58 and then when on 8/14/2024 Residents #54 and #58 were observed kissing and before today she was unaware Resident #54 was having sexual inappropriate behaviors. The DON was asked what has been done regarding the above allegations. The DON stated that this was a behavior, and nothing has been done. The DON confirmed she has not called the Residents' family or made any psychiatric recommendations. The DON confirmed that nothing additional has been put into place to ensure Resident #58 or any other resident's safety. The DON stated she would have to pull the facility's policy to see what it says about reporting of sexual abuse. The DON was asked if a resident who was not cognitively intact to give consent be kissed by another resident, should that be reported as an allegation of sexual abuse. The DON stated, No. The facility failed to report allegation of sexual abuse on 8/14/2024 when Resident #58, a cognitively impaired female resident, who wasn't able to give consent, was kissed by a male resident, Resident #54. 6. Review of the medical record revealed that Resident #59 was admitted to the facility on [DATE], with diagnoses including Anemia, Anxiety, Hypothyroidism, Encephalopathy, and Malnutrition. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15 indicating Resident #59 was cognitively intact. Resident required max assistance of staff to perform toileting, bed mobility, and transfer activities. Resident was assessed as always incontinent of bowel and bladder. During an observation and interview in the Resident's room on 9/9/2024 at 2:41 PM, revealed Resident #59 stated that CNA C was rude saying she refused care when she didn't. Resident #59 stated that CNA C was rough when assisting with care and when CNA C brought water to her room. Resident #59 stated these incidents occurred about a month ago, couldn't recall exact dates and stated that she reported to incident to Director of Nursing (DON) last Friday. Resident #59 was emotional and crying at times when talking during interview. During an interview on 9/9/2024 at 3:18 PM, the DON reported that she spoke with Resident #59 on 9/6/2024 and resident reported that CNA C lied about her refusal of ADL assistance. The DON stated the Resident has requested CNA C not be assigned her care. The DON stated the Resident has frequent complaints. The facility failed to report the allegation of abuse in a timely manner when Resident #59, who is cognitively intact, reported that CNA C had been rough during care and was rude. 49269

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, facility investigation review, and interview, the facility failed to provide evidence that all alleged violations of abuse were thoroughly investigated for 4 of 4 (Resident #48, #54, #58, and #59) sampled residents reviewed for abuse. The findings include: 1. Review of the facility's policy titled, Abuse-Protection of Residents reviewed 6/17/2024, revealed The facility will ensure that all residents are protected from physical and psychosocial harm during and after the investigation .methods to ensure the protection of residents during an investigation may include but not limited to Responding immediately to protect the alleged victim and integrity of the investigation Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed Immediate notification of the alleged victim's practitioner and the family or responsible party Removal of access by the alleged perpetrator to the alleged victim and that ongoing safety and protection is provided for the alleged victim and, as appropriate, other residents Notification of the alleged violation to other agencies or law enforcement authorities Evaluation of whether the alleged victim feels safe and if the he/she does not feel safe, taking immediate steps to alleviate the fear, such as room relocation, increased supervision Monitor the alleged victim and other residents at risk . Review of the facility's policy titled, Abuse-Identification of Types, reviewed 6/17/2024, revealed Sexual abuse a non-consensual sexual contact of any type with a resident Facility staff should report any suspected abuse, neglect, or exploitation .Sexual abuse is non-consensual sexual contact of any type with a resident, as defined at have the capacity to consent sexual contact is nonconsensual if the resident Appears to want the contact to occur but lacks the cognitive ability to consent . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse-Conducting an Investigation, reviewed 6/17/2024, revealed It is the policy of this facility that allegations of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation, and misappropriation of property) are promptly and thoroughly investigated. The facility will prevent further abuse, neglect, exploitation and mistreatment from occurring while the investigation is in progress; and take appropriate corrective action as a result of the investigation findings. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported Following identification of alleged abuse, the resident (s) receive prompt medical attention as necessary and the resident are protected during the investigation to prevent recurrence The alleged victim will be examined for any sign of injury, including a physical examination or psychosocial assessment When an incident or suspected incident of resident abuse and/or neglect, injury of unknown source, exploitation, or misappropriation of resident property is reported, the administrator/designee will investigate the occurrence the investigation would include but is not limited to Conducting observations of alleged victims .Conducting interviews with the alleged victim and representative, alleged perpetrator, witnesses, practitioner Conducting record review for pertinent information related to the alleged violation .such as progress notes The written summary of the investigation should include but not limited to A review of the Incident Report An Interview with the person(s) reporting the incident Interviews with any witnesses to the incident An interview with the resident, if appropriate .a review of the resident ' s medical record .an interview with the employee(s) .a review of the employee's file Interviews with staff members on all shifts having contact with the resident at the time of the incident Interviews other residents who received care or services from the alleged perpetrator A review all circumstances surrounding the incident If the accused individual is an employee, the alleged perpetrator will be removed from resident care areas immediately and placed on suspension pending results of the investigation. Retaliation by staff is abuse, regardless of whether harm was intended, and must be cited If the accused abuser is another resident, the resident must be separated while investigating the incident. Interventions must be implemented to assure the safety of all residents .Any investigation of alleged resident sexual abuse must start with a determination of whether the sexual activity was consensual on the part of the resident. A resident's apparent consent to engage in sexual activity is not valid if it is obtained from a resident lacking the capacity to consent .The administrator or their designee will keep the resident and/or his/her representative informed of the progress of the investigation. The alleged victim will be protected from retaliation .The administrator or designee will inform the resident, physician, and/or resident representative of the results of the investigation and the corrective action taken. Emotional support and counseling will be provided to the resident during and after the investigation, as needed . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled, Abuse-Reporting and Response-No Crime Suspected, reviewed 6/17/2024, revealed Ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but not later than 2 hours after the allegation is made, if the event that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the event that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides jurisdiction in long-term care facilities) All associates are mandated to immediately report suspected resident abuse and /or neglect to their immediate supervisor and/or facility representative All residents, families, resident representatives and visitors are encouraged to immediately report incidents of suspected resident abuse and/or neglect to facility administration .When an incident of resident abuse is suspected, the incident must be reported to the supervisor regardless of the time lapse since the incident occurred. The supervisor notifies the director of nursing and the executive director of the alleged incident All alleged violations .must be reported to the administrator of the facility and to other officials in accordance with State Law through established procedures .the facility should retain documentation of the report .The supervisor and /or charge nurse will illicit the following information .the name of the resident involved in the incident .date and time the incident occurred .where the incident took place .name(s) of the person(s) committing or involved in the incident .name(s) of any witnesses to the incident .type of abuse and /or neglect that was committed additional information that may be pertinent to the incident .the nurse will complete and sign the Incident Report and notify the physician and the resident's representative of the occurrence . Review of the facility's policy titled, Incident and Reportable Event Management, reviewed 9/14/2023, revealed Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) Event Management includes, but is not limited to , the following types of events Alleged Abuse Sexual, Physical, Verbal, Mental, or Exploitation . 2. Review of the medical record revealed Resident #48 was admitted revealed resident was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, Hypertension, Heart Failure, Alzheimer's Disease, and Depression. Review of Nurse's Note dated 7/19/2024, revealed Weekly summary: Resident is alert and oriented x [times] 3 and is pleasant and cooperative with staff. Is able to make some needs known and some are anticipated . Resident is incontinent of B&B [bowel and bladder] and requires assist of staff for peri care and brief changes. Requires assistance for all transfers to and from bed, wheelchair and toilet. Once in wheelchair requires assist of staff for to propel in room and hallways. Attends activities desired. Requires assist with bed mobility . (continued on next page)

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	445252	A. Building B. Wing	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Centerville	112 Old Dickson Rd Centerville, TN 37033

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview of Mental Status (BIMS) score of 12 indicating Resident #48 was moderately cognitively impaired. Resident was dependent on staff with assistance in toileting and required max assistance of staff with performing transfers. Resident was assessed as always regarding incontinence with bowel and bladder. Review of the Care plan dated 9/3/2024, revealed .The resident has episodes of urinary and bowel incontinence .Will have no skin breakdown r/t [related to] urinary incontinence. Assist with toileting as needed. BM [Bowel Movement] protocol as ordered PRN [as needed]. Medications as ordered. Peri-care as needed . During an observation and interview in the Resident's room on 9/10/2024 at 3:53 PM, Resident #48 stated that CNA D is hateful to he when she has a bowel movement in her brief. Resident reported that CNA D scolded resident for being incontinent of stool by stating that it is ridiculous, and the Resident should have called for assistance to use bedpan or go to the bathroom. Resident #48 stated she reported the incident to Licensed Practical Nurse (LPN) B several weeks ago. During an interview on 9/10/2024 at 4:04 PM, the Administrator was asked if she was aware of Resident #48's concerns or complaint regarding CNA D. The Administrator stated No. The Administrator was informed that Resident #48 voiced a complaint regarding CNA D being hateful and, gets mad at the Resident's bowel incontinence and the Resident reported CNA D made comments that it was ridiculous. The Administrator stated I haven't heard of this. I will go talk to the DON [Director of Nursing] and we will go talk to the Resident. Review of Social Services Note dated 9/10/2024, revealed ED [Executive Director] and SS [Social Services] met with resident regarding her CNA [Certified Nurse Aide] complaint. Resident was upset with CNA because of her tone, feeling that CNA tells her what to do. Resident said she likes her CNA and does not want her to be removed from her care. CNA spoken to. SS [Social Services] will follow up with resident. During an interview on 9/10/2024 at 5:08 PM, CNA D was asked if she was aware of any complaints regarding Resident #48. CNA D stated the Resident complains about, . me asking her to use the bedpan or go to the bathroom. CNA D stated that Resident #48 can use the bedpan or go to the bathroom when she wants to. CNA D was asked if she has the credentials to determine if a resident can do that or not. CNA D stated, No, I don't. CNA D was asked if she was aware that residents can have a decline in their toileting abilities and incontinence frequency. CNA D stated, Yes. During an interview on 9/11/24 at 4:23 PM, the Administrator was asked regarding the status of the investigation regarding Resident #48's concerns. The Administrator stated that she and the SS spoke with the Resident and asked if she was having any issues with any of the staff. The Resident reported that CNA D talked mean to her. The Administrator was asked, when the investigation was started. The Administrator stated, I did not start an investigation since we spoke with the Resident . The Administrator was asked if the CNA should have been reassigned until an investigation was complete. The Administrator stated, Yes. 3. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Diabetes, Acute Cholecystitis, Muscle Weakness, Reduced Mobility, Dementia, Depression, Chronic Pain, Long Term Use of Anticoagulant, Obesity, and Abnormality of Gait and Mobility. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility's Behavior Note dated 3/13/2024, revealed .Resident noted to have inappropriate verbal behaviors towards female staff Review of a facility's Behavior Note dated 6/7/2024 revealed, Resident noted this shift to be trying to kiss [Resident #58] another resident in hopes [Hopes Place (secure unit)], resident redirected and later separated r/t [related to] continuing with same behavior Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #54 has a Brief Interview of Mental Status (BIMs) of 3, which indicate the resident has cognitive impairment, required moderate and maximal assistance for Activities of Daily Living skills (ADLs), with active diagnoses of Non-Alzheimer ' s Dementia and the use of an antidepressant medication. Review of a facility's Behavior Note dated 8/14/2024 revealed, Resident noted to be kissing another female resident. Residents separated and staff doing 1:1 [one on one] with female resident Review of a (Psychiatric Evaluation Note) dated 8/19/2024 revealed .Staff did report that he was seen kissing a female resident on 8/14/2024 . Review of the Care Plan dated 8/20/2024, revealed Resident #54 was care planned for ADL self care deficit, at risk for communication problems and difficulty understanding others and making self understood, at risk of impaired cognitive ability /impaired thought process. The Resident did not have a care plan for behaviors. Review of a facility's Event Note, for Resident #54 dated 9/10/2024, after the survey team had notified the Administrator of the alleged kissing between the two Residents revealed .DON was made aware of alleged issue that occurred on 8/14/2024 between resident and male resident. Male resident was heard calling this resident over to him. This resident was then seen approaching resident and bent down. Nurse only seen back of residents' head at this time. Residents were then separated and 1:1 was provided until behaviors resolved. Local law enforcement, Ombudsman, Psych services, DON, ED, MD [Medical Director], RVP [Regional [NAME] President], RDCS [Regional Director of Clinical Services] and residents conservator .were all notified of alleged issues . The facility began an investigation after questioned by the survey team. 4. Review of the medical record revealed Resident #58 was admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, Depression, and Cognitive Communication Deficit. Review of the quarterly MDS dated [DATE], revealed Resident #58 was severely cognitive impaired and required moderate assistance from staff for ADL's care. Review of the Care plan revised 6/13/2024, confirmed Resident #58 was dependent on staff for meeting emotion, intellectual, physical and social needs related to cognitive deficits, and had self-care performance deficits, at risk for elopement due to wandering, behavior problems or wandering and confusion due to diagnosis of dementia, impaired cognitive ability, impaired thought process due to dementia, impaired ability to understand others and impaired ability to make self understood, at risk for elopement due to wandering, and at risk for change in mood or behavior due to anxiety, depression, and dementia, and the use of antidepressants. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed the facility failed to initiate an investigation into the incident when Resident #54 attempted to kiss Resident #58 on 6/7/2024 and when Resident #54 and Resident #58 were observed kissing on 8/14/2024 until 9/10/2024 after it was brought to their attention on 9/8/2024. During an interview on 9/10/24 at 8:33 AM, LPN F, confirmed she was the nurse assigned to the unit on 6/7/2024 and on 8/14/2024, when Resident #54 attempted to kiss Resident #58 and again when they were witnessed kissing on 8/14/2024. LPN F confirmed that she reported the incident to the Director of Nursing (DON). LPN F was asked what was done after she reported the incident to the DON. LPN F confirmed that she tried to keep the Residents separated as much as possible. LPN F stated she does not recall if she notified the family representatives at that time. LPN F confirmed that they should have been notified at that time. LPN F confirmed she did not complete an incident report, and it should have been one completed at the time of the incident. LPN F confirmed these sexual inappropriate behaviors should not occur. LPN F was asked if she witnessed behaviors of sexual inappropriateness what should be done. LPN F stated that it should be reported to the DON, and they would talk about it and decide what should be done. LPN F was asked is Resident #54 and #58 have the cognition to give consent for a kiss. LPN F stated, I don't think so LPN F was asked should this be reported as an allegation of abuse. LPN F stated, Yes. During an interview on 9/10/24 at 8:08 AM, the Administrator confirmed she was the Abuse Coordinator, and any allegation of abuse should be immediately reported to her, the DON, and ADON in her absence. The Administrator confirmed when there is an allegation of abuse, statements from both staff and residents are obtained, the medical record is reviewed of the involved residents and an investigation is started. The Administrator was asked how sexual abuse and behaviors differentiated. The Administrator stated if there is a sexual allegation, the resident would be sent to the hospital to be evaluated. The Administrator was asked were you aware of the incident that occurred on 6/7/2024 when Resident #54 attempted to kiss Resident #58 and then again on 8/14/2024 when it was witnessed them kissing. The Administrator stated she was aware of the Residents holding hands but was not aware of the 6/7/2024 or the 8/14/2024 kissing incidents. During an interview on 9/10/24 at 4:14 PM, the DON stated she was the Abuse Coordinator for the facility and any allegation should be reported to her. The DON the kissing between the two Residents should be investigated and depending on the outcome of the investigation will you let you know if it was abuse or not. Review of the medical record revealed that Resident #59 was admitted to the facility on [DATE] with diagnoses including Anemia, Anxiety, Hypothyroidism, Encephalopathy, and Malnutrition. 5. Review of the medical record revealed that Resident #59 was admitted to the facility on [DATE], with diagnoses including Anemia, Anxiety, Hypothyroidism, Encephalopathy, and Malnutrition. Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15 indicating Resident #59 was cognitively intact. Resident required max assistance of staff to perform toileting, bathing, bed mobility, and transfer activities. Resident was assessed as always incontinent of bowel and bladder. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview in the Resident's room on 9/9/2024 at 2:41 PM, Resident #59 stated that CNA C was not truthful when saying she had refused care when she had not refused care. Resident #59 stated CNA C was rough when providing assistance and was rude when she had brought water into her room. Resident #59 stated the above incidents occurred about a month ago however she could not recall exact dates. Resident #59 stated she reported these incidents to Director of Nursing (DON) last Friday. Resident #59 was emotional and crying at times when talking during interview. During an interview on 9/9/2024 at 3:18 PM, the DON reported that she spoke with Resident #59 on 9/6/2024 and the Resident reported that CNA C lied about her refusal to accept ADL care. The DON stated the Resident requested CNA C not be assigned to her. There was no documentation of a facility investigation into the alleged abuse of Resident #59 until the surveyor team requested the investigation. The facility began the investigation during the survey on 9/11/24. Refer to 609 49269

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 49269 Based on facility policy review, observation and interview the facility failed to ensure medications were properly stored when opened and undated medications were found in 1 of 6 medication storage areas (West Hall #1 Medication Cart). Findings include: Review of the facility's policy titled Storage and Expiration Dating of Medications, Biologicals dated 8/7/2023, revealed .Facility should ensure that medications and biologicals are stored in an orderly manner in cabinets, drawers, carts .Once any medication or biological package is opened .Facility should staff should record date opened on the primary medication container [vial, bottle, inhaler] .Facility should ensure that the medications and biologicals for each resident are stored in the containers in which they were originally received . Observation of the [NAME] Hall #1 Medication Cart on 9/11/2024 at 10:02 AM, revealed the following medications opened, unlabeled and undated medications loose in the medication cart drawer. a. ProAir inhaler b. Albuterol Sulfate inhaler During an interview on 9/11/2024 at 10:02 AM, Licensed Practical Nurse (LPN) A confirmed that the inhalers should be dated and labeled with the resident ' s name. During an interview on 9/12/2024 at 8:45 AM, the Director of Nursing (DON) was asked if medications in the medication storage areas should be labeled and dated. The DON confirmed that all medications should be labeled with the resident's name and dated.