STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, Facility #1 medical record review, facility investigation review, Hospital #2 medical record review, Facility #2 medical record review, Emergency Medical Services (EMS) report review, police report review, and interview the facility failed to provide an environment free from all types of abuse including, deprivation of goods and services by staff, sexual abuse by a resident, physical abuse by a family member, and verbal abuse by a staff member for 7 of 21 sampled residents (Resident #4, #5, #2, #3, #35, #19, and #49) reviewed for abuse. On 7/7/2024, Certified Nursing Assistant (CNA) O entered Resident #5's room and saw Resident #4 with her face leaning over the groin area of Resident #5, who quickly pulled up his pants when the CNA entered the room. CNA O failed to immediately intervene and left the two residents alone. The Facility failed to supervise Resident #4, a cognitively impaired resident, that exhibited wandering tendencies to prevent the resident from entering in other resident's rooms, placing the resident at risk for Sexual abuse. On 5/8/2024, Resident #2 alleged Resident #3 walked into her room, naked from the waist down, climbed into her bed, and attempted to penetrate her anally, which caused psychosocial HARM for Resident #2 and Resident #7. On 12/21/2023, 2 CNAs failed to prevent and intervene when Resident #35, a vulnerable resident with Intellectual Disability, was physically abused by Family Member (FM) FFFF which resulted in actual HARM when she sustained scratches on her chest and psychosocial HARM to the resident. Facility staff failed to identify Resident #19's long and recent history of cocaine abuse and failed to monitor to ensure the resident did not gain access to or consume illicit/street drugs, which resulted in actual HARM when Resident #19 overdosed in the facility, was found unresponsive, and admitted to the hospital on 11/8/2023. The facility's failure to prevent sexual abuse for Resident #4, Resident #5, Resident #2, and Resident #3, recognize and intervene when Resident #35 was physically abused, and identify Resident #19's extensive history of illicit/street drug abuse, placed Resident #4, #5, #2, #3, #35, and #19 in Immediate Jeopardy (IJ), a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident. The facility failed to prevent an incident of verbal abuse when CNA XXXX called Resident #49 derogatory names which did not rise to an IJ level. The Administrator was notified of the Immediate Jeopardy for F-600 on 9/19/2024 at 6:12 PM in the Conference Room. On 10/18/2024 at 12:16 PM, the Administrator was notified of an addendum to the IJ for F-600 in the Conference room. The facility was cited at F-600 at a scope and severity of L, which constitutes Substandard Quality of 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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The Immediate Jeopardy began on 11/8/2023 and is ongoing. A partial extended survey was conducted on 9/19/2024 through 11/7/2024. The facility is required to submit a Plan of Correction. The findings include: 1. Review of the facility policy titled, Abuse Prohibition Plan, dated 10/24/2022, revealed .The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse .The resident shall not be subjected to mistreatment, neglect .The facility shall attempt to identify and shall investigate any reported violation or allegation of abuse .Abuse Coordinator .in the facility is the Administrator .Abuse .means the willful infliction of injury with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse .Verbal Abuse .means the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents .or within their hearing distance .Sexual Abuse is non-consensual sexual contact of any type with a resident. It includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault .Physical Abuse .includes, but not limited to hitting, slapping, pinching, and kicking .Mental Abuse .includes .humiliation, harassment, threats of punishment or deprivation .Neglect .means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .Mistreatment .means inappropriate treatment or exploitation of a resident .Criminal sexual abuse .includes sexual intercourse with a resident by force or incapacitation or through threats of harm to the resident .Serious bodily injury also includes sexual intercourse with a resident who is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act . Review of the facility's policy titled, Baseline Careplan, with a revision date of 10/25/2023, revealed .The facility shall develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meets professional standards of care .The baseline care plan shall .Be developed .upon a resident's admission or as close to then as possible .Interventions shall be initiated that address the resident ' s current needs including .Any identified needs for supervision, behavioral interventions . Review of the facility policy titled, Behavioral Health Services, with a revision date of 10/2/2023, revealed .To ensure that residents receive necessary behavioral services .'Substance Abuse Disorder' is defined as recurrent use of alcohol and/or drugs that cause clinically and functionally significant impairment, such as health problems or disability .Behavioral health encompasses a resident's whole emotional and mental well-being, which included, but is not limited to, the prevention and treatment of .substance abuse disorders . The facility shall consider the acuity of the resident population . 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included Traumatic Subarachnoid hemorrhage, Essential Hypertension, and Dementia. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #4's Clinical Notes by Licensed Practical Nurse (LPN) B dated 3/16/2024 at 12:45 PM, revealed .Resident wanders up and down hallways in facility and hard to redirect. Resident wandered into another male resident room and acted like resident was going to kiss male resident. Resident redirected out of room . Review of Resident #4's Clinical Notes by LPN M dated 3/25/2024 at 1:57 PM, revealed .Resident continues with difficulty in redirection .entering other residents [resident's] rooms, putting her arms around them .The nurse found male resident in WC [wheelchair] who wanders behind closed door in [Resident #4]'s room . Review of the Quarterly MDS dated [DATE] revealed Resident #4 scored a 5 on the BIMS assessment, which indicated severely impaired cognition. Review of Resident #4's Clinical Note by the Director of Social Services dated 7/5/2024 at 11:24 AM, revealed .It was discussed during morning meeting that resident was wandering into the room of a male resident thinking hehe [he] was her husband . Review of Resident #4's Nurse's Event Note by LPN M dated 7/7/2024, revealed .At appx. [approximately] 1845 [6:45 PM] CNA [CNA O] came up to Nurse's station and said she needed a nurse, this nurse asked what was going on and CNA stated that [Resident #4] was in .with [Resident #5] performing oral sex, upon entering [Resident #5]'s room he was noted lying flat on his back with HOB [head of bed] down, [Resident #4] was sitting on the right side edge of the bed with her left arm supporting herself on the left of the mattress across [Resident #5]'s body near his right hip .This nurse then noticed the curtain had been pulled to obscure the roommates view, [Resident #4] was then guided out of the room to her own room and [Resident #5] . requested to remain in his own room .By that time the CNA who had told this nurse about the incident stated she did not actually see [Resident #5]'s penis, but that when she opened the door [Resident #4]'s arms were resting along side either of his hips and he was doing up his pants really fast . Review of a statement taken by the Assistant Director of Nursing (ADON) and LPN L revealed Resident #4 stated, .I entered the room and he [Resident #5] was already in the room .I heard another voice and I assumed there was someone in the other bed. I felt him [Resident #5] pushing/pulling me down toward his groin and opening his zipper at the same time .He was trying to force me to have oral sex. I told him No I don't do that. I asked him what the f . was he .trying to do and he never said a word . Review of a written statement from CNA O dated 7/7/2024, revealed .was in the process of picking up trays and opened .[Resident #5] ' s room and saw [Resident #5] quickly pulling his pants up and [Resident #4] was hovering over him . Review of a written statement from CNA QQQ dated on 7/7/2024, revealed .when I was at the nurses [nurses '] station, the dayshift tech [CNA] came up and said that [Resident #4] was in [Resident #5] room doing a [an] inappropriate act on [Resident #5] . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Police Department #1 ' s Incident Report dated 7/8/2024, revealed .Victim [Resident #4] Suspect [Resident #5] .I arrived on scene and spoke to nurse .She stated that the CNA informed her that she walked into [Resident #5] ' s room and witnessed [Resident #4] performing oral sex on [Resident #5] .[LPN M] . stated that [Resident #4] is known to wonder around the halls and cozy up with different residents .The nursing staff did state that [Resident #5] can be manipulative, and that they don ' t want him taking advantage of [Resident #4] and other patients .I spoke to [Resident #4] about the incident and her recollection of the events. She stated that [Resident #5] flagged her down and asked her if she would come inside his room. She stated that she did enter his room to make small talk with him, and that she sat on his bed. She stated that once she tried to leave the room [Resident #5] asked her to stay and grabbed her by the hand .he put it in his open pants fly and he made her touch his penis .she stated shortly after he grabbed her by the head and tried to force her to perform oral sex .He [Resident #23] .stated that [Named Resident #4] and [Named Resident #5] know each other very well, and that they had sexual relations in a closet last Friday [7/5/2024]. He stated that [Resident #4] is always coming over tot [to] their room and that this was not the first time she had been inside. He stated that once [Resident #4] entered the room, [Resident #5] shut the door and pulled the dividing curtain between them . Review of Hospital #2 ' s H and P [History and Physical] dated 7/8/2024, for Resident #4 revealed .presents to the ER [emergency room] for evaluation after a possible assault .Patient is noted to have history of dementia. She is oriented to self but not to time. She is a poor historian and is often tangential [speak about topics unrelated] .From available record review from the ER, it appears that patient, EMS and police all had a different account. Per triage note, reportedly witnesses saw a male resident in patient ' s room pulling his pants up. Patient reported in the ER that a man walked into her room at the facility and pulled his pants down and attempted to sexually assault patient. Patient later reported in the ER that a few people passed by her open room door at facility and came to hold her down to help them and assault her. ER staff attempted to contact patient ' s conservator who is her daughter, adult protection services and nursing facility. There was no response and voicemails were all left .When asked about earlier incident, she states that a bad incident happened with a man at the nursing facility but she [was] unable to specify any further . Review of the facility investigation dated 7/12/2024, revealed .Alleged perpetrator [Resident #5] states there was no sexual contact and insist they [Resident #4 and Resident #5] were watching TV. Roommate [Resident #23] states that they had not engaged in sexual activities but they were going to when CNA came into room. No other residents reported sexual abuse from the perpetrator. Alleged perpetrator has BIMS of 13 and alleged victim has BIMS of 5. Victim has diagnosis of Dementia and has tendency to roam to other rooms in the facility. Hospital reported there were no signs of penetration or indication there was sexual abuse. Police conducted investigation and stated they would follow up if needed. Conclusion: Not Verified. At the conclusion of the investigation sexual abuse could not be verified. Although the optics were bad there was no evidence that sexual abuse happened. Hospital report and statement of victim supports this conclusion . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Altered Mental Status, Depression, and Diabetes Mellitus. Review of the Admission MDS dated [DATE] for Resident #5 revealed a BIMS score of 11 which indicated moderately impaired cognition. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #5 ' s Clinical Notes Report dated 7/7/2024, revealed . It was reported that this resident forced another resident [Resident #4] to perform a sexual act . Review of Resident #5 ' s Clinical Notes Report dated 7/8/2024, revealed .924 [9:24 AM] .Stood outside the room .before I went in .I looked over to my left and he is masturbating. Would not stop . Review of Resident #5 ' s Clinical Notes Report dated 7/8/2024, revealed .1300 [1:00 PM] .Interviewed resident with admin [Administrator] about allegation of inappropriate sexual behavior. At the beginning of the interview resident was resistant to speaking of what occurred between resident and female resident [Resident #4]. After speaking with resident and asking him to be truthful, resident stated that he believed that resident [Resident #4] was A&O [Alert and oriented] and not confused. he [Resident #5] stated that he had pulled privacy curtain down between him and roommate and pulled his pants down with the anticipation of a sexual encounter between him and female resident. resident [Resident #5] stated several times that nothing occurred sexual between them and female resident [Resident #4] but then stated that inappropriate contact between him and resident [Resident #4] had occurred. [Resident #5] stated he was not aware that resident [Resident #4] was confused and not able to give consent .explained to resident that female resident [Resident #4] from previous night was not able to consent . Review of NP MM ' s Progress Note for Resident #5 dated 7/8/2024, revealed .On 7/7 [2024] it was alleged that patient sexually abused another [Resident #4]. It was reported that this resident forced another resident to perform a sexual act .[Roommate Resident #23] was interviewed to this alleged event and he stated that [Resident #4] has come to the room on multiple occasions and that on Friday night [Resident #5] and [Resident #4] were in the bathroom for an hour together where he could hear [Resident #4] giving the [Resident #5] oral sex. [Roommate Resident #23] stated that yesterday [Resident #5] was planning it all day. [Resident #5] stated that he was looking for [Resident #4] and then when she came to his room [Resident #5] close [closed] the curtains around his bed, [Resident #5] turned the television on and [Roommate Resident #23] could hear [Resident #5] speaking softly to [Resident #4] and that she was in bed with him. [Roommate Resident #23] stated that [Resident #4] always came to the room on her own. Roommate stated .[Resident #5] stated that nothing has happened between them [Resident #4 and #5] and [Roommate Resident #23] stated, [Resident #5] is lying. [Roommate Resident #23] stated it was the same woman [Resident #4] several times and you could here [hear] sexual acts going on between [Resident #4 and #5]. Nurse documented in [Resident #4] chart that she walked into [Resident #5] room and opened the curtain and found the female propped up on her elbows with her face in the area of [Resident #5 ' s] hips. [Resident #5] jerked up his pants so she did not see any body parts . Nursing staff reported that they found [Resident #5] masturbating this morning .I saw this patient this morning, and he came up to me this morning like he usually does and asking me what I was doing today not acknowledging that he was standing too close to me per usual .I explained to patient that I would be interviewing him due to activities that took place over the weekend and he stated ' I did not do anything to her. ' Patient knew exactly what incident I was speaking of .there were eyewitnesses to him and the female engaging in sexual acts together and he stated ' we actually have not done anything. ' I explained to him that they were found in bed together and he stated ' we were just watching TV ' .he stated ' she has come twice to my room but I have not done anything either time. ' . [Resident #4] who was involved .has a BIMS of 6, diagnoses of dementia with behavioral disturbance . moderate severe dementia. Fluctuating between oriented x [times] 1 [to self only] to oriented x 3 [to person, place, and time]. Frequently confused .poor judgment and insight, always notably confused . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the medical record revealed Resident #23 (Resident #5 ' s roommate) was admitted to the facility on [DATE] with diagnoses which included Pressure Ulcer of Sacral Region, Stage 4, Chronic Kidney Disease, Type 2 Diabetes Mellitus, and Obstructive and Reflux Uropathy. Review of the Quarterly MDS dated [DATE] revealed Resident #23 had a BIMS score of 15 which indicated no cognitive impairment. During an interview on 10/3/2024 at 4:00 PM, Resident #23 (roommate of Resident #5) stated, .[Resident #4 and Resident #5] was in the bathroom for an hour the night before [7/7/2024] from 11:30 PM to 12:30 PM .I know I looked at that clock on the wall .[Resident #4] came in here all the time . Resident #23 was asked if he witnessed anything on 7/8/2024 between the two residents. Resident #23 acknowledged, (Resident #4) was performing oral sex on (Resident #5). Review of the medical record revealed Resident #32 was admitted to the facility on [DATE] with diagnoses which included Displaced Spiral Fracture shaft of Right Tibia, Major Laceration of Liver, Unspecified Laceration of Spleen, Unspecified Fracture of the Sacrum, and Unspecified Hearing Loss. Review of the Admission MDS revealed Resident #32 had a BIMS score of 14 which indicated no cognitive impairment. Review of the Clinical Notes for Resident #32 dated 7/10/2024, revealed .Notified DON that resident was rubbed on the shoulder by a female resident [Resident #4] .He waved at the staff from the activity room for someone to come in and get her . During an interview on 10/10/2024 at 2:15 PM, the MDS Coordinator stated, .[Resident #4] just touched him [Resident #32] on the shoulders .she was just getting in his personal space rubbing his shoulders .[CNA F] wrote a statement .we hadn ' t moved [Resident #4] over to the 300 hall yet she was still on the 700 hall . The facility was unable to provide this surveyor the written statement from CNA F. During a telephone interview on 10/10/2024 at 3:07 PM, CNA F stated, .I witnessed her [Resident #4] touching the other male resident on his shoulders .I can ' t remember his name but he was deaf .I looked toward the activity room and seen it .I reported it to the nurse because I thought I was supposed to .we separated them and put them on 1 on 1 observation . During an interview on 10/11/2024 at 12:50 PM, the Administrator stated, .after the incident on 7/8/2024 we placed the two residents on one on one .[Resident #4] was discharged to the hospital .On 7/10/2024 [Resident #4] readmitted to the facility and she was seen touching the male resident [Resident #32] in the activity room so we had the psychologist evaluate her and then we moved her to the 300 hall . During an interview on 10/14/2024 at 2:30 PM, the MDS Coordinator was asked what was put in place to prevent Resident #4 from wandering when it was noted from 3/16/2024 to 7/5/2024 that she was wandering into other resident rooms. The MDS Coordinator stated, .a wanderguard was placed on 3/3/2024 .on 7/7/2024 she was placed on 1 on 1 and the care plan was implemented on 7/8/2024 .7/12/2024 she was placed on the 300 unit . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 9/6/2024 at 11:04 AM, CNA H stated, .[Resident #4] has a history of wandering. I ' ve seen [Resident #4] wander into other resident rooms several times prior to the incident . A week or so before the incident occurred, I found [Resident #4] in [Resident #5] ' s room sitting on his bed. It was around midnight. I didn ' t report it to anyone or document it anywhere . During a telephone interview on 9/6/2024 at 1:42 PM, CNA G stated, . [Resident #5] would wander the hallway and look into resident ' s rooms especially the women . During an interview on 9/6/2024 at 3:27 PM, CNA O stated, .I was picking up dinner trays and noticed [Resident #5] ' s door was shut. The curtain in between residents was pulled. I opened the door and [Resident #5] had his pants down and [Resident #4] ' s head was toward his groin area. [Resident #5] was hurrying to pull up his pants. Went over to where the roommate was, and the roommate said they just pulled the curtain. I left out of the room and ran to get the nurse .[Resident #4] wandered a lot. I didn ' t separate the residents immediately but probably should have . During an interview on 9/10/2024 at 10:31 AM, the Administrator stated he was the abuse coordinator and the DON was the backup abuse coordinator. The Administrator was asked what he expected staff to do when they witness any type of abuse. The administrator replied he expected staff to separate the residents immediately, report the incident to a supervisor, and notify administration. During an interview on 10/1/2024 at 2:10 PM, the ADON stated, I was told to come out to the building they caught [Resident #4] in the room with [Resident #5] the Social Service Director (SSD) and I talked with [Resident #4] .she was telling me he was trying to make her do something but she couldn ' t really explain it . she had dementia really bad .she would lose her train of thought .[Resident #4] often walked the floor .would say that is my husband [referring to male residents at the facility] .[Resident #5] was discharged the next day . [Resident #23] did say they were in the room together .he could hear them at one point in the night and said they had been in the bathroom together one time too . The ADON was asked if Resident #4 could consent for sexual activity. The ADON stated, . In [Resident #4] ' s [cognitive] state she wouldn ' t have had that capacity . During a telephone interview on 10/2/2024 at 2:18 PM, NP/APRN stated, .the ADON called me that day [7/8/2024] and said [Resident #4] walked in [Resident #5] ' s room . The NP was asked why the ADON would call her to tell her a resident walked into another resident's room. The NP stated, .[Resident #4] was sitting on [Resident #5] ' s bed and he had his pants down .[Resident #4] went to the hospital and when she came back, she didn ' t recall anything .[Resident #5] was discharged . NP was asked if Resident #5 had the capacity to consent to sexual activity. The NP stated, .yes . The NP/APRN was asked if Resident #4 had the capacity to consent to sexual activity. The NP stated, .I think she could say yes or no . The NP/APRN was asked if Resident #4 had Dementia and she stated, .yes .I still think she could consent . The NP/APRN was asked could a resident with Dementia make sound decisions. The NP stated, .she had Dementia .our desires and medical decisions are different it doesn ' t mean she doesn ' t have a natural desire for things . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 10/3/2024 at 9:40 AM, NP MM stated, .[Resident #4] apparently was the aggressor coming in frequently to visit [Resident #5] . [Resident #5] had a child like mentality but I think he knew it was wrong .he allowed it to happen .she was confused going around to men .the roommate [Resident #23] heard everything, he saw it and told all the stories .I personally don't feel like [Resident #4] would have the capacity to make higher level decisions .I saw her walking into the dining room massaging on [Resident #32] .She couldn ' t give me any details about the incident .[Resident #5] denied they done anything in the bathroom and then [Resident #4] was in the room with him and [Resident #5] closed the curtain . During an interview on 10/8/2024 at 11:00 AM, RN UUU stated, .[Resident #4] doesn ' t have the mentality to consent to sexual relations . During an interview on 10/10/2024 at 1:42 PM, LPN SSS stated, .I can ' t remember the man [Resident #4] was touching on the 400 hall .the man couldn ' t talk real good .he was yelling for staff to get her .she was rubbing his chest inappropriately .the ADON and Administrator was notified .the ADON said it was a reportable . The interviews revealed no effective interventions were implemented by the facility to prevent Resident #4 ' s wandering behavior prior to the incident with Resident #5 on 7/8/2024. During a telephone interview on 10/15/2024 at 12:48 PM, DON LL stated, I was not notified that a nurse found a male resident in a wheelchair behind a closed door in [Resident #4] ' s room .I should have been notified .we have to figure out what they were doing and come up with an intervention to prevent it from happening again .[Resident #4] was new to us .she had dementia and wandered some .I know she was confused and difficult to redirect . During an interview on 10/22/2024 at 10:42 AM, Psychologist #1 stated she was informed by staff that Resident #4 was possibly involved in sexual activity with another resident. A staff member saw them (Resident #4 and Resident #5) in the bed together and roommate (Resident #23) said they were in bed together. Psychologist #1 was asked if a resident with a BIMS score of 5 could understand the risks involved with sexual activity. Psychologist #1 stated, .Yes .they can be taught .she [Resident #4] was good at reading situations .the facility didn ' t ask me to do a capacity to consent .She [Resident #4] made lewd [legal term that refers to sexual conduct that is considered offensive] comments . (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 11/6/2024 at 4:54 PM, the Regional Nurse was asked if Resident #4, with a BIMS score of 5, could give clear accounts to what happened between her and Resident #5. The Regional Nurse stated, .I don ' t know if she could clearly, but she said nothing happened either time .that is why we sent her out for sexual exam . The Regional Nurse was asked if the facility investigated Resident #23 ' s report of Resident #4 and Resident #5 being in the bathroom together. The Regional Nurse stated, .it was reported at the same time .we interviewed the roommate [Resident #23] .I went over to his bed and from that side you couldn ' t see in the bathroom .I asked him about the bathroom incident . The Regional Nurse was asked if staff interviews were conducted with staff that worked on the night Resident #23 reported the two residents were in the bathroom together. The Regional Nurse stated, I asked the staff about abuse. The Regional Nurse stated, .[Resident #23] said they were in the bathroom together .we wouldn ' t know what happened in the bathroom .he [Resident #23] was lying .he said he didn ' t see or hear anything . The Regional Nurse was asked if Resident #23 told her he was lying. The Regional Nurse stated, .he didn ' t tell me he was lying . no . The Regional Nurse stated, .she [Resident #4] went out [to the hospital] came back .he [Resident #5] was discharged .she was on 1 on 1 after her hospitalization . The Regional Nurse was asked if Resident #4 was on 1 on 1 observation how was she able to put her arms around Resident #32. The Regional Nurse stated, .I am hoping the person was in the dining room with her, but I am just making an assumption . Review of the written statements consisted of statements from 26 random staff members that verified they have not witnessed abuse of any kind in the facility. The statements did not question the staff about Resident #4 and Resident #5 being in bathroom together or having any type of relations during the time at the facility. 3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included Gastroenteritis, End Stage Renal Disease, and Essential Hypertension. The face sheet revealed Resident #2 was responsible for herself. Review of the 5-day MDS dated [DATE], revealed Resident #2 scored an 11 on the BIMS assessment which indicated moderately impaired cognition. Continued review of the MDS revealed Resident #2 had no indicators for Psychosis or behavior symptoms. Further review of the MDS revealed Resident #2 required substantial/maximal assistance with toileting, partial/moderate assistance with bathing and lower body dressing, and Resident #2 was always incontinent of urine and bowel. Review of Resident #2 ' s Psychiatric Evaluation dated 5/6/2024, revealed .Patient showing fair judgement and insight into her current course of care and why she is at the facility. Patient showing the ability to process, obstruction rationalize information .Oriented x 3. No issues with long-term or short-term memory impairment noted. Attention concentration was good .Patient showing no signs of AMS [altered mental status], able to rationally discuss medical course, able to discuss risk versus benefits of care. Patient currently showing signs of capacity to make medical decisions . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of Resident #2 ' s Clinical Notes Report with effective date 5/9/2024, revealed .1000 [10:00 AM] .On 5/9/24 [2024] .I was doing my morning medical [medication] pass. When I [was] called into the room of [Resident #2], by [Resident #7 the roommate]. When I asked what [Resident #7] needed, she stated that she and her roommate [Resident #2] needed to be cleaned up. [Resident #7] even stated, Look at her [Resident #2] .she is covered in s .t! As I turned to investigate [Resident #2], I noticed that she was covered in her own feces. She also did not have a top sheet or a blanket on her. I asked what happed [happened] to all of her covers. [Resident #2] .told me the naked man ripped everything off, and threw all of her covers in the floor. [Resident #2] asked me if I could get her a comforter to cover her up. I promptly did so. As I was questioned [questioning] the ladies. [Resident [TRUNCATED]

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, facility investigation summary review, medical record review, and interview, the facility failed to ensure 1 (Resident #26) of 3 residents reviewed were free from misappropriation. The findings include: Review of the facility policy titled, Abuse Prohibition Plan revised 10/24/2022 revealed, .The resident shall not be subjected to .misappropriation of property .The .policy applies to anyone involved with the residents of this facility, including .all .staff .Misappropriation of Resident Property means the deliberate misplacement, exploitation .use of a resident's belongings .without the resident's consent . Review of the facility policy titled, Medication Administration: Narcotic Control Record revised 10/9/2023 revealed, .The facility shall have safeguards in place in order to prevent .diversion .The facility shall utilize the Narcotic Control Record so that all controlled medications can be reconciled and counted at the change of each shift .The total number of narcotic sign out sheets .and cards shall be kept on the record and counted by the oncoming and the outgoing nurse at each shift change .The nurse shall update the record so that the count shall be correct when narcotic deliveries are made from the Pharmacy, when a resident completes a narcotic .Once all of the rows on the Narcotic Control Record are filled in completely, 2 nurses must transfer the count over to a new record and sign verifying the numbers were transferred accurately .The completed Narcotic Control Records shall be kept secured by the facility DON [Director of Nursing] or designee along with the Narcotic Count Sheets and retained XXX[AGE] years after the discharge of the resident . Review of the Facility Investigation Summary dated 2/24/2024 completed by Registered Nurse (RN) LL, revealed, Reported to [Licensed Practical Nurse (LPN) WW] that [Resident #26] did not have scheduled medication [Hydrocodone 10mg/325mg] .The medication had been delivered on 2/19/24 and the medication could not be found in the facility .All nurses were drug tested .except for .[named Registered Nurse (RN) YY] . On 2/21/24 the [narcotic card] count decreased, but no documentation of what [narcotic] card was removed from the cart .All nurses have not been drug screened . There is no documentation in the facility investigation to show the agency nurse, RN YY was reported to the agency for failure to submit a drug screen during the facility investigation of the missing Hydrocodone. There was insufficient evidence to support how the narcotic card was not accounted for. Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses of Cerebrovascular Disease, Hemiplegia, and Chronic pain. Review of the Physician Order Sheet dated February 2024, for Resident #26 revealed, on 1/16/2024 a physician order for Lortab [narcotic pain medication] 10 mg [milligram]- 325 mg tablet take one tablet by mouth three times a day for 60 days starting on 1/16/2024. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment /Order Update/Change in Condition dated 2/24/2024, for Resident #26 revealed, a telephone order to begin on 2/24/2024 and end on 3/24/2024 for Hydrocodone (Lortab) 10mg-acetaminophen 325mg tablet take one (1) tablet by mouth three times a day taken by the ADON. Review of the Medication Administration Record (MAR) dated 2/1/2024 through 2/29/2024, for Resident #26 revealed, RN YY did not document medication administration on 2/13/2024 for Lortab 10 mg-325 mg tablet to be given one (1) tablet by mouth three times a day at 8:00 AM and 4:00 PM administration times. On 2/24/2024 the 8:00 AM dose of Lortab 10 mg-325 mg tablet to be given one tablet by mouth three times a day was not documented as administered. Review of the CONTROLLED DRUG RECEIPT/RECORD/DISPOSITION FORM dated 2/13/2024 through 2/23/2024, for Resident #26 revealed, on 2/13/24 at 10:00 AM, RN YY signed out one Lortab (Hydrocodone) 10/325 for Resident #26. Review of the facility's NARCOTIC CONTROL RECORD dated 2/14/2024 through 2/22/24 revealed, RN YY documented one narcotic card was removed from the narcotic box but did not document what card was removed. The discrepancy of the removed narcotic card was not resolved. RN YY did not document on the 2/2024 MAR that the Hydrocodone was administered. Review of the Care Plan dated 2/24/2024, for Resident #26 revealed interventions related to medication diversion. Review of the nurses note for Resident #26 dated 2/26/2024, revealed, .Notified Metro police .related to [drug diversion] event on 2/24/24 . All nurses were drug tested except RN YY. RN YY stated was unable to return to facility (out of town, did not know when she would return). RN YY was not drug tested . Personnel record requested for RN YY. RN YY was an agency nurse. RN YY did not work at the facility following this incident involving missing Hydrocodone 10/325- #30 tablets. During an interview on 10/3/2024 at 8:45 AM, LPN XXXXX stated she put the drug card and manifest in the narcotic drawer of med cart. During an interview on 10/1/2024, RN LL (the former DON) stated the facility was unable to determine who was responsible for the missing hydrocodone. RN LL stated all nursing staff were drug tested except RN YY, an agency nurse, refused to come to the facility for the investigation. RN LL stated RN YY did not work at the facility following the drug diversion. RN LL was uncertain if the staffing agency was notified that RN YY refused drug screen. During interview on 10/30/2024 at 2:22 PM, the DON reviewed the Narcotic sign out log, the February 2024 Medication Administration Record (MAR) for Resident #26, and the facility investigation of the missing Hydrocodone. The DON confirmed the facility investigation was incomplete and did not determine who was responsible for misappropriating the Hydrocodone. The DON confirmed the Hydrocodone discrepancy on 2/21/2024 occurred during RN YY's shift, the nurse for Resident #26 on 2/13/2024 and 2/21/2024.

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** 44724 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to timely report allegations of abuse and neglect for 5 of 21 (Resident #2, #3, #19, #4, and #5) sampled residents reviewed for abuse. The facility failed to report an allegation of sexual abuse to the State Survey Agency within 2 hours when Resident #2 reported/alleged to staff on 5/8/2024 at approximately 11:00 PM that Resident #3 assaulted her through anal penetration. The facility failed to report Resident #19 ' s cocaine overdose in the facility on 11/8/2023 at approximately 8:30 PM, within 2 hours to the State Survey Agency. The facility ' s failure to ensure all allegations of abuse and neglect were reported immediately resulted in an Immediate Jeopardy (IJ) for Resident #2, #3, and #19. An 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 facility failed to report an allegation of sexual abuse to the State Survey Agency after staff witnessed alleged sexual abuse for Resident #4 and Resident #5 which did not rise to an IJ level. The Administrator was notified of the Immediate Jeopardy for F-609 on 10/21/2024 at 5:44 PM in the Conference Room. The facility was cited at F-609 at a scope and severity of K, which constitutes Substandard Quality of Care. The Immediate Jeopardy began on 11/8/2023 and is on-going. A partial extended survey was conducted on 10/21/2024 to 11/7/2024. The facility is required to submit a Plan of Correction (POC). The findings include: 1. Review of the facility ' s policy titled, Abuse Prohibition Plan, dated 11/2/2023, revealed, .External Reporting .Reports to the State agency shall be made electronically by use of the state electronic reporting system or alternatively by fax. 2 HOUR TIME LIMIT .All alleged violations are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury . 2. Review of the medical record revealed Resident #2 was admitted on [DATE] and discharged on [DATE] with diagnoses which included Gastroenteritis, Chronic Kidney Disease, End Stage Renal Disease, and Essential Hypertension. Review of the 5-day MDS assessment dated [DATE] revealed Resident #2 scored an 11 on the BIMS assessment which indicated moderately impaired cognition. Continued review revealed Resident #2 had no indicators for Psychosis or behavior symptoms. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the medical record revealed Resident #3 admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included Enterocolitis due to Clostridium Difficile, Unspecified Abdominal Pain, and Dementia. Review of the Admission MDS with assessment reference date 5/9/2024 revealed Resident #3 scored a 7 on the BIMS assessment which indicated severely impaired cognition. Continued review revealed Resident #3 wandered daily, placed the resident at risk of getting in a dangerous place, and significantly intruded on the privacy of others. Review of Police Department #1 ' s Incident Report dated 5/9/2024 at 9:54 PM, reveal .Incident Date Time From .5/8/2024 21:30 [9:30 PM] To .5/9/2024 21:54 [9:54 PM] Offense Code .Forcible Fondling .Offense Description SEXUAL BATTERY, WOMAN .Weapon Code .PERSONAL (HANDS, ECT. [Et Cetera]) . Victim [Resident #2] .Victim to Suspect .[Resident #3] .WITNESS .[Resident #7] .Injured VICTIM 1 [Resident #2] . Administration provided video footage with a time stamp 05/09/2024 at 0303 [3:03 AM] hours showing [Resident #3] at the end of the hallway completely naked. Officers observed at 0307 [3:07 AM] hours [Resident #3] then entered a room and at 0313 [3:13 AM] hours exit a room and was then assisted by staff at the facility . The police report revealed Resident #3 continued to wander the hall naked after the allegation of sexual abuse occurred on 5/8/2024 at 11:00 PM which placed other vulnerable residents in the facility at risk for sexual abuse. Review of the IRS dated 5/9/2024 completed by Facility #1 revealed, .Abuse specify .Sexual .Date/Time Administrator was notified of the incident .5/9/2024 8:30 AM . Allegation of sexual assault reported .Date and time when the alleged incident occurred .5/8/2024 11:00 PM . The IRS revealed the allegation of sexual abuse was reported on 5/9/2024 a day after the alleged sexual incident occurred on 5/8/2024. Review of a Coaching and Counseling Session form dated 5/9/2024 with Registered Nurse (RN) CC revealed .Allegation of abuse made by Resident [Resident #4] during this Nurse ' s shift on 5/8/24 [2024]. Nurse failed to Immediately Report to Supervisor .Unit manager, ADON [Assistant Director of Nursing], DON, or Administrator .Report All Allegations Immediately as a Mandatory Reporter .Separation of employment . Employee Comments I am very sorry for any harm to the resident. I take full responsibility for my lack of action. I knew better .Investigation Complete Termination Do Not Re-Hire . RN CC failed to report the allegation of sexual abuse to the Abuse Coordinator. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 9/12/2024 at 1:32 PM, Former Interim DON(DON) stated, I was in the car on the way to the facility around 8:30 AM got a call from the ADON (Assistant Director of Nursing). Resident #2 alleged that someone came in her room and put their penis in her butt and the other Resident was Resident #3. At shift change on the morning of 5/9/204, RN KKK reported to the ADON about the incident. Resident #2 alleged sexual abuse. I conducted an investigation and determined that the entire night shift knew about the sexual abuse allegation but did not report it. I spoke to the assigned tech Certified Nursing Assistant (CNA J) for Resident #2 and she stated Resident #2 told her what happened to her, and she reported it to the nurse (RN CC) and that the nurse told her (CNA J) that it was a busy night and that Resident #2 makes up stories all the time and don ' t tell anyone else that. No one on that night shift reported the sexual abuse allegations. I suspended RN CC then terminated her upon completion of the investigation. During a telephone interview on 10/3/2024 at 10:56 AM, RN CC stated, .I failed to report the allegation of sexual abuse .I was sitting at nurses' station .[CNA J] and [Licensed Practical Nurse LPN MMM] were whispering .basically I heard a little .I asked the CNA what was going on and she said [Resident #2] alleged this man [Resident #3] raped her .I heard the nurse tell her oh she is crazy .[LPN MMM] was an agency nurse .I told [LPN MMM] the resident maybe crazy but you still have to report it .the nurse just brushed it off .I had dealt with [Resident #3] earlier he was walking hall naked and a CNA had to go get a gown and put a brief on him .he had went into another female residents room and sat on her bed .that was hours earlier . RN CC was asked at any point during the night shift was Resident #3 placed on 1 on 1 supervision. RN CC stated, .No, mostly just trying to redirect him .I wish I would have done better .I hate that resident went through that . During a telephone interview on 10/8/2024 at 121:27 AM, the Former Interim DON stated, .I don ' t recall talking to [LPN MMM] .but [RN CC] said everybody knew about it and they were told to keep their mouth shut . 3. Review of the medical record revealed Resident #19 was admitted to the facility on [DATE], with diagnoses including Osteomyelitis of Vertebra, Sacral and Sacrococcygeal Region, Pressure Ulcer of Sacral Region-Stage 4, Fracture of Unspecified Neck of Right Femur, Diabetes Mellitus, Hypertension, Protein-Calorie Malnutrition, and Depression. Review of the 5-day MDS dated [DATE], revealed Resident #19 scored a 15 on the BIMS assessment, which indicated he was cognitively intact, and was dependent on staff for all activities of daily living (ADLs). Review of the Incident Reporting System (IRS) report for Resident #19 dated 11/9/2023 at 4:45 PM, revealed the Administrator was notified of the incident on 11/8/2023 at 9:30 PM. Continued review of the IRS report revealed, On 11/8/23 [2023] resident [#19] was seen by facility staff alert and oriented X3 [to person, place, and time] at approximately 8PM [8:00 PM]. Resident had an unidentified visitor that entered his room at approximately 8:20PM. After visit, resident was found unresponsive at approximately 8:40PM. Resident was treated immediately until EMS [Emergency Medical Services] arrived. On 11/9/2023 DON [Director of Nursing LL] contacted hospital for update and was made aware that resident was being treated for cocaine overdose. Date and time when the alleged incident occurred .11/08/2023 8:30 PM .Resident was immediately assessed and treated with Narcan [medication to reverse opioid overdose] prior to EMS arrival. Immediately after resident departure to hospital, staff removed a paper bag from residents [resident ' s] room. The bag was secured until police could examine what appeared to be an illicit substance inside . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Discharge Summary from Hospital #2 dated 11/13/2023, revealed Resident #19 admitted to the hospital on 11/8/2023. Resident #19 reported to staff that he overdosed on what he thought was heroin that a family member brought him, however, Resident #19 ' s drug screen revealed cocaine with metabolites (the presence of cocaine or one of the chemicals your body makes to process cocaine] was found in his urine. Resident #19 was admitted to the Intensive Care Unit and required an intravenous drip of Narcan. Resident #19 discharged home with home health on 11/13/2023. During a telephone interview on 10/2/2024 at 8:36 AM, Administrator #3 confirmed he was the Administrator at Facility #1 from September 2023 until February 2024. Administrator #3 stated he was responsible for reporting reportable incidents to the appropriate agencies. Administrator #3 was asked what the process was for reporting abuse allegations. Administrator #3 stated, The process is we report abuse within 2 hours, any allegation of abuse we report. Administrator #3 was asked what about neglect. Administrator #3 stated, The same .We didn ' t feel like necessarily it was an abuse situation. The guy [Resident #19] had potentially gotten some drugs in the building . Administrator #3 was asked when he was notified of the incident. Administrator #3 stated, I would have to look back to get you a definite answer I ' m pretty sure it was that night .pretty certain . The facility reported Resident #19 ' s overdose on 11/9/2023 at 2:00 PM, the day following the incident. During an interview on 10/15/2024 at 11:11 AM, the DON reviewed the investigation the facility provided for Resident #19 ' s overdose in the facility on 11/8/2023. The DON was asked how soon that (Resident #19 ' s overdose) should be reported to the State. The DON stated, Within 2 hours. The DON acknowledged the overdose occurred on 11/8/2023 and was not reported to the State Survey Agency until 11/9/2023. The DON was asked did the facility submit the incident to the State timely. The DON stated, No. The facility failed to report Resident #19 ' s cocaine overdose in the facility to the State Survey Agency within 2 hours. 4. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included Traumatic Subarachnoid hemorrhage, Essential Hypertension, and Dementia. Review of the Quarterly MDS dated [DATE] revealed Resident #4 scored a 5 on the BIMS assessment which indicated severely impaired cognition. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Altered Mental Status, Depression, and Diabetes Mellitus. Review of the Admission MDS dated [DATE] revealed Resident #5 scored an 11 on the BIMS assessment which indicated moderately impaired cognition. Review of the IRS report dated 7/7/2024, completed by Facility #1 revealed .Abuse specify .Sexual . Date/Time .staff became aware of the incident .07/07/2024 7:00 PM .Date/Time administrator was notified of the incident .07/07/2024 7:30 PM .Alleged Perpetrator [Resident #5] .What was reported and to whom or which agency/entity .Sexual assault to police, APS [Adult Protective Services], Ombudsman and state health department .Submission Report .Date/time .report was submitted .07/07/2024 10:15 PM . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The IRS revealed the allegation of sexual abuse was reported to the State Agency on 7/7/2024 at 10:15 PM, 3 hours and 15 minutes after the alleged sexual assault occurred. During an interview on 9/10/2024 at 10:31 AM, the Administrator stated he was the abuse coordinator. The DON was his backup abuse coordinator. He stated he was responsible to report abuse allegations to the state agency within 2 hours. The Administrator acknowledged that the abuse [7/7/2024] was reported past the 2-hour timeframe. Refer to F-600 and F-610.

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, facility investigation review, medical record review, and interview, the facility failed to conduct a thorough investigation and take appropriate corrective actions for 6 of 21 (Resident #4, #5, #2, #3, #7 and #19) sampled residents reviewed for abuse. The facility failed to conduct a thorough investigation into an allegation of sexual abuse between Resident #4, a vulnerable, cognitively impaired resident with a diagnosis of dementia, and Resident #5 on 7/7/2024. The facility failed to conduct a thorough investigation into Resident #2's allegation that Resident #3 sexually assaulted her through anal penetration on 5/8/2024, which resulted in psychosocial harm and delayed incontinence care for the victim. The facility failed to conduct a thorough investigation into Resident #19's cocaine overdose in the facility on 11/8/2023. The facility's failure to perform a thorough investigation resulted in an Immediate Jeopardy for Resident #4, #5, #2, #3, #7, and #19. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator was notified of the IJ for F-610 on 10/21/2024 at 5:55 PM in the Conference room. The facility was cited at F-610 at a scope and severity of K., which constitutes Substandard Quality of Care. The Immediate Jeopardy began on 11/8/2023 and is ongoing. A partial extended survey was conducted on 9/19/2024 through 11/7/2024. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	1. Review of the facility policy titled, Abuse Prohibition Plan, with effective date of 11/2/2023, revealed .The facility has a zero-tolerance policy for abuse. Verbal, mental, sexual, or physical abuse .is prohibited. The resident shall not be subjected to mistreatment, neglect .The facility shall attempt to identify and shall investigate any reported violation or allegation of abuse. The Abuse Policy applies to anyone involved with the residents of this facility, including, but not limited to, all facility staff, other residents, consultants .staff or other agencies serving the resident .Alleged Violation .is a situation or occurrence that is observed or reported by staff, resident .another healthcare provider, or others but has not yet been investigated .The Administrator shall investigate or assign the investigation to designated facility personnel such as the Director of Nursing (DON). The investigation shall begin immediately. The information gathered, and the findings/conclusion shall be provided to the Administrator .The individual conducting the investigation shall, at a minimum .Review the completed allegation/incident documentation .Review the Resident's medical record to determine events leading up to the incident .Interview the person(s) reporting the incident .Interview any witnesses to the incident .Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .Review all events leading up to the alleged incident .Each interview shall be conducted separately and in a private location .Witness reports shall be reduced to writing. Witnesses shall be required to write a statement and be interviewed by the Abuse Coordinator/designee. They shall review the interview, then sign and date it, attesting to its accuracy. (Note: A copy of such reports must be attached to the investigation report) .All staff are required to cooperate during the investigation to assure the resident is fully protected .There may be some situations in which the psychosocial outcome to the resident may be difficult to determine or incongruent with what would be expected. In these situations it is appropriate to consider how a reasonable person in the resident's circumstances would be impacted by the incident .Upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident .If sexual abuse is suspected, the Resident SHALL NOT be bathed, and clothing or linen shall not be washed. No items shall be removed from the area in which the incident occurred. The police shall be called immediately .For the protection of all individuals involved, copies of any internal reports, interviews, witness statements, photographs or video surveillance gathered during the investigation shall be released only with permission of the Administrator or the Facility Attorney . Review of the facility policy titled, Video Surveillance, with effective date of 5/28/2024, revealed .To establish guidelines related to the use of video monitoring of resident and staff in order to evaluate and maintain a safe and therapeutic treatment environment. Use of video surveillance system may also .Assist the Administrator or designee with incident investigation .Assist the treatment team in defining or updating patient therapeutic interventions, including but not limited to, confronting issues of denial, aggressive behaviors, maladaptive coping skills, drug diversion .The facility shall utilize monitoring as deemed appropriate to promote resident care and the overall safety of residents .If a recording is used in connection with an incident under investigation by Administrator or designee, at the discretion of the Administrator or designee, it may be retained indefinitely or until the case investigation has closed. The Administrator shall keep such recordings archived with date, time and location in a designated area . 2. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included Traumatic Subarachnoid hemorrhage, Essential Hypertension, and Dementia. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 scored a 5 on Brief Interview for [NAME] Status (BIMS) assessment which indicated severely impaired cognition. Review of the Nurse ' s Event Note for Resident #4 dated 7/7/2024, revealed at approximately 6:45 PM a Certified Nursing Assistant (CNA) requested the assistance of a nurse in Resident #5's room. The CNA reported to the nurse she had walked in on Resident #4 performing oral sex on Resident #5. The nurse entered Resident #5's room to find him lying flat on his back, with the head of the bed down and Resident #4 sitting on the right side of the bed positioned over Resident #5's right groin area. The nurse noted the privacy curtain had been pulled to obscure Resident #5's roommate's (Resident #23) view. The CNA reported when she opened the door Resident #4's arms were resting along side both of Resident #5's hips and Resident #5 quickly pulled his pants up. Review of the facility investigation dated 7/12/2024 revealed on 7/7/2024 at 7:00 PM, CNA O found Resident #4 sitting on Resident #5's bed. Resident #5 was lying in the bed with his pants pulled down. Licensed Practical Nurse (LPN) M was notified and upon entering the room she saw Resident #5 pulling up his pants. Staff was interviewed and statements were taken. Resident #5 stated there was no sexual contact and insist they were watching TV. Resident #5's roommate (Resident #23) stated Residents #4 and #5 were about to engage in sexual activities when CNA O came into the room. The facility concluded there was no evidence of sexual abuse. Review of the police report dated 7/8/2024 revealed, .Victim [Resident #4] Suspect [Resident #5] .I spoke to nurse .[nurse] stated that the CNA informed her that she walked into [Resident #5]'s room and witnessed [Resident #4] performing oral sex on [Resident #5] .I spoke to [Resident #4] about the incident and her recollection of the events. She stated [Resident #5] grabbed her by the hand .he put it in his open pants fly and he made her touch his penis .she stated shortly after he grabbed her by the head and tried to force her to perform oral sex .[Resident #5] .stated .[Resident #4 and Resident #5] had sexual relations in a closet last Friday [7/5/2024] . Resident #4 reported allegations of sexual abuse occurred to Police Department #1 this was not included in the facility investigation. Resident #5 reported to the Police Department #1 that on Friday 7/5/2024 sexual relations occurred between the two in a closet. This was not included in the facility investigation. 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses which included Cerebral Infarction, Altered Mental Status, Depression, and Diabetes Mellitus. Review of the Admission MDS for Resident #5 dated 5/13/2024 revealed a BIMS score of 11, which indicated moderate cognitive impairment. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Clinical Notes Report for Resident #5 dated 7/8/2024, revealed .1300 [1:00 PM] .Interviewed resident with admin [Administrator] about allegation of inappropriate sexual behavior. At the beginning of the interview resident was resistant to speaking of what occurred between resident and female resident. After speaking with resident and asking him to be truthful, resident stated that he believed that resident was A&O [Alert and oriented] and not confused. he stated that he had pulled privacy curtain down between him and roommate and pulled his pants down with the anticipation of a sexual encounter between him and female resident .resident stated several times that nothing occurred sexual between them and female resident but then stated that inappropriate contact between him and resident had occurred. [Resident #5] stated he was not aware that resident was confused and not able to give consent . Review of Nurse Practitioner (NP) MM's Progress Note dated 7/8/2024 for Resident #5 revealed, .On 7/7 [2024] it was alleged that patient sexually abused [Resident #4] .Roommate [Resident #23] was interviewed to this alleged event and he stated that the female has come to the room on multiple occasions and that on Friday [7/5/2024] night he and the woman were in the bathroom for an hour together where he could hear the woman giving the patient oral sex. Roomate [Roommate-Resident #23] stated that yesterday his roommate was planning it all day. Patient stated that he was looking for her and then when she came to his room he closed the curtains around his bed, [Resident #5] turned the television on and he could hear him speaking softly to the woman .[Resident #23] stated it was the same woman several times and you could here [hear] sexual acts going on between them. Nurse documented in the woman's chart that she walked into this patient's room and opened the curtain and found the female propped up on her elbows with her face in the area of [Resident #5]'s hips. [Resident #5] jerked up his pants .Nurse reported that [Resident #5] and . [Resident #4] looked very surprised .I saw this patient this morning .I explained to patient that I would be interviewing him due to activities that took place over the weekend and he stated 'I did not do anything to her. ' Patient knew exactly what incident I was speaking of .there were eyewitnesses to him and the female engaging in sexual acts together . Review of a typed interview statement performed by Regional Nurse Manager (RNM) and RNM #2 revealed an interview with Resident #23 on 7/8/2024. Resident #23 reported to the ADON that Resident #4 and Resident #5 were in the bathroom together Friday (7/5/2024). The ADON interviewed Resident #4 regarding the allegation of being in the bathroom with Resident #5 and she stated, no Resident #5 was interviewed, and he denied being in the bathroom with Resident #4. The RNM and RNM #2 interviewed Resident #23 for the second time and he again stated that he saw them enter the bathroom together. Resident #23 reported he saw Resident #4 come into his room and that she was on Resident #5's side of the room on 7/8/2024. Resident #23 stated he couldn't see what they were doing because the privacy curtain was pulled at the time. Resident #23 stated, he couldn ' t hear what they were saying to each other, but he assumed that something was going to go down but the staff member came in and caught them before they had a chance to do anything. The interview revealed the roommate (Resident #23) alleged Resident #4 and Resident #5 were in the bathroom together on 7/5/2024. The facility interviewed Resident #4 who had a BIMS score of 5 with a diagnosis of Dementia who was unable to give a clear statement related to the incident on 7/5/2024. 4. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses which included Pressure Ulcer of Sacral Region, Stage 4, Chronic Kidney Disease, Type 2 Diabetes Mellitus, and Obstructive and Reflux Uropathy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Quarterly MDS dated [DATE] revealed Resident #23 had a BIMS score of 15 which indicated no cognitive impairment. During an interview on 10/1/2024 at 2:10 PM, the ADON stated, .I was told to come out to the building they caught [Resident #4] in the room with [Resident #5] .the staff had taken her out of his room .the SSD [Social Service Director] and I talked with [Resident #4] .she was telling me he was trying to make her do something but she couldn ' t really explain it .she had dementia really bad .she would lose her train of thought .[Resident #23] did say they were in the room together .he could hear them at one point in the night and said they had been in the bathroom together one other time to . The facility investigation revealed no documentation or statements from employees related to Resident #4 and Resident #5 being in the bathroom together. During a telephone interview on 10/3/2024 at 9:40 AM, Psychiatric NP MM stated, .[Resident #4] apparently was the aggressor coming in frequently to visit [Resident #5] .He [Resident #5] had a child like mentality but I think he knew it was wrong .he allowed it to happen .she was confused going around to men .the roommate heard everything, he saw it and told all the stories .the facility sent her out .She couldn't give me any details about the incident .[Resident #5] denied and denied they done anything in the bathroom and then she [Resident #4] was in the room with him and [Resident #5] closed the curtain . During an interview on 10/3/2024 at 4:00 PM, Resident #23 stated, .they [Resident #4 and Resident #5] was in the bathroom for an hour on Friday night before from 11:30 PM to 12:30 PM .I know I looked at that clock on the wall .the woman came in here all the time . During an interview on 11/4/2024 at 9:48 AM, CNA O stated, .I was picking up trays, [Resident #5]'s door was shut I opened it and he had his pants down and [Resident #4] had her head down at the crotch area. [Resident #5] was able to walk and had pulled the curtain. He [Resident #5] quickly started pulling up his pants and [Resident #4] just looked at me. I shouldn't have left but I was shocked when I seen it. [Resident #23] was upset because [Resident #5] had pulled the curtain and shut the door . The facility investigation did not include information related to CNA O leaving Resident #4 and #5 alone after she witnessed the two residents in the male resident's room with door shut, curtain pulled, with Resident #5 with his pants down. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/6/2024 at 4:54 PM, the Regional Nurse was asked if Resident #4 with a BIMS score of 5 could give clear accounts to what happened between her and Resident #5. The Regional Nurse stated, .I don't know if she could clearly, but she said nothing happened either time .that is why we sent her out for sexual exam . The Regional Nurse was asked if the facility investigated Resident #23's report of Resident #4 and Resident #5 being in the bathroom together. The Regional Nurse stated, .it was reported at the same time .we interviewed the roommate [Resident #23] .I went over to his bed and from that side you couldn't see in the bathroom .I asked him about the bathroom incident . Review of the 26 employee statements provided in the investigation revealed all 26 employees denied witnessing any abuse, at any time while employed in the facility. The Regional Nurse was asked if staff interviews were conducted with staff that worked on the night Resident #23 reported the two residents were in the bathroom together. The Regional Nurse stated, I asked the staff about abuse. The Regional Nurse was asked to review the 26 employee statements provided in the investigation. The Regional Nurse was asked if she could determine what specific questions were asked in the interview by reading the statements. The Regional Nurse responded, .I know what was being investigated, I assume the questions were related to the incident [allegation of sexual conduct between Resident #4 and Resident #5]. Review of the facility investigation revealed the facility did not conduct a thorough inquiry into Resident #4 and #5 being in the bathroom together or any past physical or psychological relationship while in the facility. _____ 5. Review of the medical record revealed Resident #2 was admitted on [DATE] and discharged on [DATE] with diagnoses which included Gastroenteritis, Chronic Kidney Disease, and End Stage Renal Disease. Review of the 5-day MDS assessment dated [DATE] revealed Resident #2 scored an 11 on the BIMS assessment which indicated moderately impaired cognition. Review of the facility Incident Reporting System (IRS) report dated 5/9/2024 revealed Resident #2 alleged Resident #3 sexually assaulted her on 5/8/2024. The alleged perpetrator was Resident #3. Resident #3 had recently become combative and resistant to redirection. The facility reported an allegation of sexual assault with no visible bruising, scratches, lacerations, or bleeding for Resident #2. Resident #2 became withdrawn and was showing expressions of fear. Resident #7 witnessed the alleged abuse. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The 5-day follow up report submitted to the State Agency on 5/14/2024 revealed Resident #2 appeared somewhat withdrawn after the incident took place. The alleged victim stated that a male, without any clothes on entered her room and laid on the bed with her and attempted to penetrate her from behind with his penis. All staff were interviewed; however, no one witnessed the actual abuse of the alleged victim. The victim's roommate (Resident #7) was in her own bed at the time the incident took place. The privacy curtain between the two beds partially obstructed her view, but she did say that a naked man came into the room and laid down next to the victim on her bed. The charge nurse was unaware of anything taking place until she was directed to the alleged victim's room by other staff. The staff responsible for oversight of the alleged perpetrator were not aware of anything out of the ordinary taking place until they heard the alleged victim scream for help. No clinical or physical abnormalities were discovered after the alleged incident took place. Conclusion of the facility's investigation revealed, The allegation could not be verified because the resident changed her story from one day to the next. 6. Review of the medical record revealed Resident #7 was admitted on [DATE] and discharged on [DATE] with diagnoses which included Epileptic Seizure, History of Transient Ischemic Attack and Cerebral Infarction. Review of the Quarterly MDS assessment dated [DATE] revealed Resident #7 scored a 15 on the BIMS assessment which indicated intact cognition. Review of the Clinical Notes Report for Resident #2 with effective date 5/9/2024, revealed Registered Nurse (RN) KKK was notified by Resident #7 (Resident #2)'s roommate that she and her roommate needed to be cleaned up. RN KKK noticed Resident #2 was covered in her own feces and did not have a top sheet or a blanket on her. Resident #2 reported a male resident (Resident #3) came into her room naked, ripped everything off, and threw all of her covers in the floor. Resident #2 stated, I don't know why that naked man keeps coming in my room at night. He even tried to stick his penis inside my butt last night and got this shit all over his penis! Resident #2 and Resident #7 confirmed the incident happened last night (5/8/2024) and this was reported to the nurses last night. Resident #7 stated, Yes, I saw it happen: We both were screaming for him to get out! RN KKK immediately reported the allegation to the ADON. The ADON and RN KKK then went to report the allegation of sexual assault to the Administrator. Review of the Clinical Notes Report dated 5/9/2024, revealed Resident #2 alleged another resident (Resident #3) came into her room and got in the bed with her and attempted to place his penis in her rectum. The Former Interim DON and NP/Advance Practice Registered Nurse (APRN) performed a head-to-toe assessment and noted no abnormal findings of bruising, abrasions, or bleeding. Review of the Social Service Director note dated 5/9/2024, revealed Resident #2 reported Resident #3 came into her room and put his penis in her anus. Resident stated that she yelled for her tech to come and get him out because he wouldn ' t leave when she and her roommate asked him to leave. Resident #2 stated (Resident #3) pulled her blanket down and got into bed with her. Resident #2 stated this occurred around 11:00 PM and he (Resident #3) was naked from the waist down when he entered. Review of the Nurse's Event Note dated 5/9/2024 for Resident #2 revealed, .Resident stated that male resident entered her room during the night .was half clothes [clothed] with penis exposed, climbed into her bed with her .tried to have anal sex with her. She said he hit her on the hip . (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	7. Review of the medical record revealed Resident #3 admitted to the facility on [DATE] and discharged [DATE] with diagnoses which included Enterocolitis due to Clostridium Difficile, Unspecified Abdominal Pain, and Dementia. Review of the Admission MDS with assessment reference date 5/9/2024, revealed Resident #3 scored a 7 on BIMS assessment which indicated severely impaired cognition. Review of Police Department #1's Incident Report dated 5/9/2024 at 9:54 PM revealed Resident #2 stated that Resident #3 entered her room completely naked. Resident #3 entered her bed and reached his hand beneath her diaper and touched her rectum with his penis. Resident #2 stated she was shouting at him to get off and to leave and Resident #3 told her to shut up. Resident #2 stated she had been having stool issues and that her diaper contained her feces and as a result she observed Resident #3 had feces on his penis. Resident #3 then left her bedroom and sent back into the hallway. Administration provided video footage with a time stamp 5/09/2024 at 3:03 AM showing [Resident #3] at the end of the hallway completely naked. The officers observed at 3:07 AM [Resident #3] then entered a room and at 3:13 AM, he exited a room and was then assisted by staff at the facility. Due to camera footage the officers were unable to confirm what room Resident #3 entered. Review of Police Department #1's incident report did not contain information related to evidence of the sheet Resident #3 used to clean feces from his penis. The report does not reflect the video surveillance was reviewed for the correct date or time of the reported incident 5/8/2024. The Police Department #1's report revealed Resident #3 continued to wander naked in the facility placing other residents at risk for abuse. During a telephone interview on 9/12/2024 at 11:18 AM, RN KKK stated, when he came into work that morning, a couple of employees were talking about how they found a man in the hallway half naked on the previous night before. RN KKK noticed a resident (Resident #2) was in a fetal position and had dried stool all over her and didn't have covers over her. I asked the resident why she was laying there with no covers and she stated that a man took them from her. The resident stated that a man came in her room and tried to stick his penis in her butt last night, and he got mad when she defecated on herself then took her covers to clean himself off then threw the covers in the corner. RN KKK stated he seen the covers in the corner, so the story did make sense. Resident #7 stated that they (Resident #2 and Resident #3) screamed for him to get out and cut on the call light, but no one came. RN KKK stated he reported it to the ADON as soon as he was told about it from the two residents. The incident should have been reported during the night shift. The facility investigation did not include information related to the sheet used by Resident #3 to clean feces from his penis. The investigation did not include information related to the disposition of the soiled sheet evidence. This evidence was not reported or given to the police as per the facility policy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 9/12/2024 at 1:32 PM, the Former Interim DON stated Resident #2 alleged that someone came in her room and put their penis in her butt and the other Resident was Resident #3. I spoke with [Resident #3] who said no to every question I asked him. Then [Resident #3] said if I did it, I don't remember I did it. At shift change on the morning of 5/9/2024 [RN KKK] reported to the ADON about the incident. [Resident #2] alleged sexual abuse. I conducted an investigation and determined that the entire night shift knew about the sexual abuse allegation but did not report it. I spoke to the assigned tech [CNA J] for [Resident #2] and she stated [Resident #2] told her what happened to her, and she reported it to the nurse [RN CC] and that the nurse told her that it was a busy night and that]Resident #2] makes up stories all the time and don ' t tell anyone else that. No one on that night shift reported the sexual abuse allegations. I suspended [RN CC] then terminated her upon completion of the investigation. There should be statements in the investigation from [RN CC], [LPN MMM], and [CNA J] [staff assigned to care for Resident #2 on 5/8/2024] regarding that night shift. Review of the facility reported investigation revealed no signed statement from RN CC, LPN MMM, or CNA J. During a telephone interview on 9/17/2024 at 12:09 PM, LPN AA stated the only thing she remembers is around 1:00 AM, Resident #3 was found in the hallway naked, and he was taken back to his room to get clothes on . The interview revealed Resident #3 continued to wander the facility naked after the allegation of sexual assault occurred. The facility investigation did not contain a written statement from LPN AA. During a telephone interview on 9/26/2024 at 11:23 AM, Resident #7 (Resident #2's roommate) stated, . [Resident #3] came in showing his penis .he tried to get in the bed with her [Resident #2] .I started screaming .she had a gown on .I heard her [Resident #2] say 'what are you doing' .he is trying to have sex with me .I heard him say 'it will be over in a minute' .she started screaming .she was so sick she couldn't defend herself .we had our call light on .he finally left . Resident #7 was asked how the incident made her feel. Resident #7 stated, .It was scary .I felt like I wasn't safe .[Resident #2] cried for a little while after it happened and on the next day .[Family Member FM V] was at the facility the next day when the NP came in to see her [Resident #2] .FM V told the NP you didn't even do anything for her from 10:00 PM until the next morning . Resident #7 stated, .she laid with no covers and boo boo [bowel movement] on her until the next morning . The facility investigation did not reveal a statement from Resident #7. During a telephone interview on 9/30/2024 at 2:30 PM, Administrator #2 stated, .I do recall that incident . [Resident #2]'s story changed and in the end that didn't really happen .typically the Maintenance Director was the one that would look at the surveillance camera when we had an incident . The Administrator #2 was asked did the facility investigate as to why Resident #2 laid dirty without covers until the next morning. Administrator #2 stated, .maybe the DON did that at the time, I don ' t recall if it was investigated about why she laid in her feces .I think the DON done the investigation .I believe the DON got a statement from Resident #2 .some of the staff reported she was withdrawn .seems like we sent her to the hospital . The facility investigation did not include information related to Resident #2 being left soiled in feces for approximately 9 hours after the alleged sexual assault. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 10/1/2024 at 8:46 AM, CNA UU stated, .I was working the next morning 5/9/2024 .she [Resident #2] was laying on her side covered in dried bowel movement [BM] .she told us [Resident #3] got in bed with her and tried to penetrate her bottom .she was shocked and upset .all the night shift was gone at that point .her brief was gone .I don ' t remember if we found the brief or where it was .she had no covers on her .her roommate [Resident #7] told me he got in the bed with her .[Resident #3] would wander around naked looking for a bathroom . During an interview on 10/1/2024 at 2:00 PM, the ADON stated, .I worked on that investigation involving [Resident #2 and Resident #3] .I was told about the incident the next morning by (RN KKK) .She (Resident #2) said he [Resident #3] got in the bed with her and tried to penetrate her anally but I didn't feel she was coherent enough to know what happened .by the time I got here she was already cleaned up .I just thought surely the nurse just miss understood the CNA on night shift when she reported the incident but the nurse said she was told on night shift about the allegation of sexual abuse and failed to report it .we let the nurse go .She [Resident #2] didn't seem upset to me .I didn't review the camera's to see if he went into the room . nothing stood out to me about any changes in her . During a telephone interview on 10/2/2024 at 2:18 PM the Nurse Practitioner/Advanced Practice Registered Nurse (NP/APRN) stated, .I went to see her [Resident #2] that morning [5/9/2024]. She was still in the bed. She told me that he [Resident #3] crawled in bed with her removed her brief .she said there was no penetration .her story was different at one point she said she had on a brief and then she said she removed it to have a bowel movement (BM) . The APRN stated, .she was alert and oriented .the family was involved they came to see her that day .I didn't see any tears or redness . The NP/APRN was asked if she assessed Resident #2 prior to her being cleaned up. The APRN stated, .no she was already cleaned up .I am not qualified to do a rape exam .[Resident #3] did wander .[Resident #7] said it scared her, she heard [Resident #2] scream and she saw the naked man in the room .[Resident #2] was fine . The interview revealed Resident #2 was physically assessed after she had been cleaned up. The facility policy revealed a resident involved in a sexual assault should not be bathed prior to the examination. During a telephone interview on 10/1/2024 at 2:28 PM, Maintenance GGG (Past Maintenance Director) stated, .I did review the surveillance cameras at times when the facility needed me to .I was unable to save the videos to a drive I could only record the videos with my phone. I still have some videos on my phone .I will have to look and call you back . During a telephone interview on 10/2/2024 at 3:31 PM, Maintenance GGG stated, .I was unable to find any of the videos that I had saved for the facility .I have looked through my emails to the Administrators and I can't find any copy of the videos . The facility did not retain video footage rela [TRUNCATED]

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record reviews, and interviews, the facility failed to ensure transfer/discharge information was documented in the medical record and communicated to the receiving provider for 6 of 6 residents (Resident #44, #43, #52, #53, #54 and #51) reviewed for transfer/discharge. The findings include: Review of the facility's policy titled, Transfer and Discharge revised 10/24/2022, revealed, . Emergency Transfers/Discharges-for medical reasons, or for the immediate safety and welfare of a resident .Obtain physicians ' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis .Complete and send with the resident a Transfer to Hospital Form which documents .Current diagnosis and reasons for transfer .Contact information of the practitioner responsible for the care of the resident . Resident representative information including contact information . Current medications, treatments, labs and or radiological findings, and functional status . Special instructions or precautions for on-going care .Comprehensive care plan goals .Any other documentation, as applicable, to ensure a safe and effective transition of care . Review of the medical record revealed Resident #44 was admitted to the facility on [DATE] with diagnoses which included Altered Mental Status, Alzheimer ' s Disease with Late Onset, Unspecified Severity with Other Behavioral Disturbances and Delusional Disorders. Review of the Hospital Transfer Form for Resident #44 dated 10/5/2023 at 11:30 PM, revealed, .Name of Provider Approving Transfer: [left blank] .CONTACT PERSON BELOW WAS NOTIFIED: [named Family Member-FM RRRRR] .Telephone: [left blank] .SELECT THE ONE MAIN REASON FOR TRANSFER (i.e. [example] What Happened?) .Dementia .List of Diagnoses: [left blank] .Vital Signs: N/A [Not Applicable] . CAPABILITIES OF THE FACILITY TO CARE FOR THE RESIDENT: [left blank] .Report Called To: [left blank] . Review of the Clinical Note for Resident #44 with an entry date of 10/5/2023 at 11:16 PM revealed, .Resident is alert to name. Trying to go in other resident room. Hard to redirect, will not listen. Resident behavior getting worst send to hospital. Son notified .: Review of the Clinical Note for Resident #44 with an entry date of 10/5/2023 at 11:35 PM revealed, .At 1915 [7:15 PM] resident was noted ambulating halls, talking to inanimate objects, and wandering into other resident's rooms .Severe communicative deficit noted as resident spoke word salad and did not seem to understand what was spoke to him .[Resident #44] was not re-directable .Resident became combative and slapped staff member multiple times during her attempts to keep him out of other's rooms. NP [Nurse Practitioner] .called and order received for Haldol [medication used to treat severe behavior problems in patients with dementia] 3mg [milligrams] to be given IM [Intramuscular] x [times] 1 now .There was no noted efficacy with injection and resident continued to wander feverishly. He went into a female resident's room and laid down in the extra bed. Staff was unable to get him to move from the bed. NP was again consulted, and order was received to transfer resident to ED [Emergency Department] for psychological evaluation. He left in the custody of EMS [Emergency Medical Services] and [Named Local Fire Department] headed to [named Hospital #3] at 21:30 [9:30 PM] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

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Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMS Prehospital Care Report for Resident #44 dated 10/5/2023 revealed, . dispatched to a nursing home for a [AGE] year old male [Resident #44] with psychiatric problems .Pt [patient] has Alzheimer's and dementia. Facility stated they did not know the pt normal [usual behavior] due to this being his first day at the facility. Per facility the pt was going in and out of other residences [resident ' s] rooms and refused to leave. Pt was combative with staff. They administered 5mg of Haldol IM prior to EMS arrival .Pt is now calm and cooperative . No incidents occurred . EMS at scene at 2122 [9:22 PM] .EMS departed at 2134 [9:34 PM] . Review of the medical record revealed Resident #44 was readmitted to the facility on [DATE] with diagnoses which included Altered Mental Status, Alzheimer ' s Disease with Late Onset, Unspecified Severity with Other Behavioral Disturbances and Delusional Disorders. Review of the Clinical Note for Resident #44 dated 11/09/2023 at 4:27 AM, revealed, .Pt wandering throughout facility and uncooperative with redirect attempts. Pt went into conference room and locked himself in and would not come out despite attempts to talk him out of the room. Pt was pulling fecal matter out of his incontinent brief. Call placed to on call NP, DON [Director of Nursing] & 911 at 2156 [9:56 PM]. Metro Police and EMS arrived at 2205 [10:05]. DON gave instructions to get key to conference room and door opened. Pt cleaned once staff, EMS and Metro Police was able to get pt to cooperate. Pt transferred to [named Facility #5] for evaluation per NP instructions. Report called to [named Hospital #5] ED . Per clinical note, patient report was called to Hospital #5 and Resident #44 was transferred to Hospital #3. Per clinical note there was no mention of suicidal attempts or ideations. Review of Hospital Transfer Form for Resident #44 dated 11/9/2023 at 10:20 PM, revealed, .CONTACT PERSON BELOW WAS NOTIFIED: [named Family Member-FM RRRRR] .Telephone: [left blank] .CODE STATUS: [left blank] .SELECT THE ONE MAIN REASON FOR TRANSFER (i.e.[example] What Happened?) .Psychiatric (Psychosis/Suicidal) .List of Diagnoses: [left blank] .Vital Signs: N/A [Not Applicable] .CAPABILITIES OF THE FACILITY TO CARE FOR THE RESIDENT: [left blank] .Report Called To: [left blank] . Review of the EMS Prehospital Care Report for Resident #44 dated 11/9/2023 revealed, .patient is inside nurses ' office and locked everyone out .sitting in chair awake and calm . awake, confused, non-violent, holding feces in his hands .chief complaint violent and manic [extremely excited or anxious] episode .Patient is able to state his name however will not talk or answer any questions. Transport will be nonemergency to [named Hospital #3] ER [emergency room] .Patient remains calm and quiet during transport .no complaints noted and no signs of discomfort or distress . Per review of EMS Prehospital Care Report patient was transferred to [named Hospital #3]. There are no mentions of suicidal attempts or ideations in report. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 10/17/2024 at 2:38 PM, Family Member (FM RRRRR) stated, .I came the next day [10/6/2024-the day after Resident #44 was admitted to Facility #1] after work to visit my dad and was told he was not here .No one called me and told me they sent him to the ER .no one could tell me where my dad was sent to and I was told by a nurse to call various hospitals to find out where he was .I had to call the police department and have them find out where he was .As soon as he came back, they sent him out again [11/9/2024] .No one from the facility called me to say he went out again .the hospital, I can ' t remember which one, called me this time and told me he was there and the facility [Facility #1] wanted to send him to another psych hospital, but the Ombudsman became involved and helped me get him to [Named Facility #6] . The facility documented notification to FM RRRRR for the transfer on 10/5/2024 and 11/9/2024. Per interview with FM RRRRR, there was no communication from the facility related to Resident #44 being transferred to the outside facilities for care. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #44 ' s medical record and acknowledged the clinical notes and transfer form required to be sent to the receiving provider was not completed before the transfer on 10/5/2024. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Unspecified Dementia with Unspecified Severity without Behavioral Disturbance, Psychotic Disturbance, or Mood Disturbance and Anxiety Disorder. Review of the Clinical Note for Resident #43 dated 7/18/2024 at 12:32 PM revealed, .Pt was transferred approximately 9:30 AM to [named Psych Hospital #2] . Review of the medical records for Resident #43 revealed no documentation of physician order for transfer/discharge initiated on 7/18/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #43 ' s medical record and acknowledged there was no documentation for a physician order to transfer out of the facility on 7/18/2024. The DON stated any transfer from the facility requires a physician order. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses which included Acute Kidney Failure, Metabolic Encephalopathy, and Dehydration. Review of the Clinical Note for Resident #52 dated 8/5/2024, at 3:30 PM revealed, .patient had labs drawn last week and today results came back with hemoglobin of 6.6, patient was transferred to ER via ambulance approximately 1:50 PM, for blood transfusion per NP . Review of the EMS Prehospital Care Report for Resident #52 dated 8/5/2024 revealed, .pt nurse states that he has abnormal lab (low hemoglobin level) and needs to be transferred out .transported non-emergency to [named Facility #3] . Review of the medical record for Resident #52 revealed there was no Hospital Transfer Form, and no physician order for transfer/discharge initiated on 8/5/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Hospital #3 ' s Physician History and Physical for Resident #52 dated 8/5/2024 at 6:56 PM revealed, .The patient is disoriented upon exam. He is unable to provide any information as to why he was transferred to the Emergency Department . During an interview on 7/10/2024 at 6:10 PM, the DON reviewed Resident #52 ' s medical record and acknowledged there was no physician order for transfer out of the facility and no hospital transfer form initiated on 8/5/2024. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE], with diagnoses which included End Stage Renal Disease, Anemia, and Atrial Fibrillation. Review of the Clinical Note for Resident #53 dated 8/10/2024 revealed, .During report it was noted that patient had been running a slight fever and not feeling well and he is to be monitored for changes. Patient wife approached the nurse and explained that due to her husband's condition getting worse throughout the evening she wanted to go ahead and send him out to the hospital . Review of the EMS Prehospital Care Report for Resident #53 dated 8/10/2024 revealed, .C/O AMS [complaint of Altered Mental Status], fever with possible sepsis [life threatening complication of an infection]. Upon arrival, report from staff states the Pt. has had a fever and received 1000mg Tylenol within the hour. The Pt.'s wife requested 911 be called for transport, stating the Pt. is altered and shaking with chills .The Pt. 's wife states this has worsened over the last couple days. The Pt. was transported to [named Hospital #3] for further evaluation and treatment . Review of the medical record for Resident #53 revealed no documentation of Hospital Transfer Form or physician order for emergency transfer/discharge initiated on 8/10/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #53 ' s medical record and acknowledged there was no physician order for transfer out of the facility and no hospital transfer form initiated on 8/10/2024. When asked if she could determine what facility Resident #53 was transferred to on 8/10/2024, the DON replied, .[Named Resident #53] was sent to [Named Hospital #4], I went over notes from morning meeting and an email from central intake at [Hospital #4] . Resident #53 was transferred to Hospital #3 on 8/10/2024. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses which included Anoxic Brain Damage, Atrioventricular Block, and Cardiomyopathy. Review of the Clinical Note for Resident #54 dated 9/16/2024 at 6:25 PM for Resident #54 revealed, .This nurse notified that resident was lethargic and eyes were red. This nurse went in and assessed resident and found resident to be lethargic with food in his mouth and unable to respond to sternum rub and pupils were fixed. This nurse then contacted [named NP] to get order to send resident out to ER for further evaluation . 911 was called and report given to send resident to [named Facility #4] for further evaluation . (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the EMS Prehospital Care Report for Resident #54 dated 9/16/2024 revealed, .Upon arrival crew directed to patient room where patient was found in hospital bed unresponsive with snoring respirations and pinpoint pupils .Initial assessment findings include airway patent but patient not awake or responsive enough to protect airway. Nasopharyngeal Airway inserted into left air and patient placed on O2 via nonrebreather mask at 15 liters per minute. Pulse present, strong and regular. Skin normal. Staff states that patient is normally awake, alert and oriented and at around 12:55 PM today he was last seen well. Family states that they arrived at facility at 1:05 PM and he was unresponsive in his bed when she alerted staff. Secondary assessment was unremarkable for any additional injury or illness findings . Review of Hospital Transfer Form for Resident #54 dated 9/17/2024 at 1:30 PM revealed, .CONTACT PERSON BELOW WAS NOTIFIED: [named Resident #54] .Telephone: [left blank] .SELECT THE ONE MAIN REASON FOR TRANSFER (i.e.[example] What Happened?) .Change In Mental Status .List of Diagnoses: [left blank] .CAPABILITIES OF THE FACILITY TO CARE FOR THE RESIDENT: [left blank] . Form Completed By: [left blank] .Report Called To: [left blank] . The Hospital Transfer Form for Resident #54 was not completed until 9/17/2024, 24 hours after the transfer and could not have been sent with the resident. Review of Hospital #4 ' s Physician History and Physical for Resident #54 dated 9/17/2024 at 1:08 PM revealed, .On 9/16, the patient ' s mother went to visit him at his SNF [Skilled Nursing Facility] and found him to be unresponsive with some shaking. EMS was called, and the patient was given Narcan [medication used to reverse opioid narcotic overdose] with improvement in mental status. In the ED, the patient was also hypotensive and was started on broad spectrum antibiotics and admitted to the MICU [Medical Intensive Care Unit] on a Narcan drip . Further review revealed, .We have not yet been able to obtain medication list from SNF and it is unclear if patient was receiving narcotics at the skilled nursing facility . During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #54 ' s medical record and acknowledged there was no physician order for transfer/discharge out of the facility and no hospital transfer form initiated on 9/16/2024. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses which included Malignant Neoplasm of Brain, Kidney Transplant Status, and Unspecified Convulsions. Review of the Clinical Note for Resident #51 dated 9/23/2024 revealed, .At 11:00 AM notified by nursing personnel that resident didn't look right obtained vital signs. Skin cool to touch. Oxygen level 77% on room air. Placed on a non-rebreather mask. Notified [named NP]. Resident was sent out via 911 stretcher to [named Hospital #4] for evaluation. Contact was notified. DON aware . Review of the EMS Prehospital Care Report for Resident #51 dated 9/23/2024 revealed, . dispatched to nursing home for breathing problem .patient was found laying supine in bed, alert but non-verbal and unable to follow commands. Facility staff stated their pulse oximeter gave an oxygen reading of 77% with a heart rate of 39 beats per minute .Patient transported non-emergent to [named Hospital #4] . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record for Resident #51 revealed no documentation of physician order for transfer/discharge on 9/23/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #51 ' s medical record and acknowledged there was no physician order for transfer/discharge on 9/23/2024. During an interview on 10/17/2024 at 12:33 PM, Licensed Practical Nurse (LPN) YYYY stated .to send a patient out we call the provider and get the order .the order is put into the computer for them [provider] to sign .a transfer form is filled out for every patient sent out of the facility .the transfer form is for our records only, it isn ' t sent with the patient .we send a face sheet, copy of the medications, advance directives, .if it is an emergency we don ' t always have time to get all of the paperwork printed off to send with them .we just keep a copy here in case the hospital calls for it . During an interview on 10/17/2024 at 12:40 PM, LPN B stated, .The nurse responsible for the resident is required to fill out the transfer form .The transfer process tells you what to print for the receiving hospital and what forms to fill out I fill out the transfer form and send it with EMS .Once the next of kin or emergency contact is notified the nurse documents it in progress notes .you only call report when you know where the patient is being transferred to .We request they go to the preferred hospital on their face sheet, but EMS makes the decision where to take them .If I know where they are going, I will call report . During an interview on 10/28/2024 at 12:36 PM, the Assistant Director of Nursing (ADON) stated, .An order must be obtained to send a resident out of the facility . If a nurse receives a verbal order from the doctor, it must be put into the computer immediately .All medications given to a patient must have a doctor ' s order . The ADON stated nursing staff should write the order down on paper, repeat the order back to the provider, enter the order into the computer, print a copy of the order entered into the computer, then place it in a basket at the desk for review by the DON or ADON. During an interview on 11/6/2024 the NP stated nursing staff are required to obtain an order for all resident transfers. The NP stated the nurse would put the order into the computer and when notified, the provider will sign the order electronically. During an interview on 11/7/2024 at 6:10 PM, the DON stated a physician order was required to transfer residents out of the facility. The DON stated she expects the transfer form to be completed accurately and sent with the resident at the time of transfer in order to ensure a safe and effective transfer of care for each resident. The DON acknowledged in an emergency situation there should be nursing staff available to ensure all of the required documents are available to be sent with the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, and interview, the facility failed to provide a bed-hold notice to the resident or resident representative at the time of transfer for 5 of 6 residents (Resident #43, #52, #53, #54, #51) reviewed for discharge. The findings include: Review of the facility policy titled, Bed Hold Notice Prior to and Upon Transfer, revision date 7/31/2023 revealed, .It is the policy of this facility to provide written information to the resident and/or the resident representative regarding bed hold policies prior to transferring a resident . At the time of transfer for hospitalization or therapeutic leave, the facility shall provide to the resident and/or the resident representative written notice . Review of medical record revealed, Resident #43 was admitted to the facility on [DATE] with a diagnosis: Unspecified Dementia, Type 2 Diabetes, Anxiety Disorder, Chronic Kidney Disease. Record review of Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #43 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Review of Social Services Director ' s (SSD) Clinical note for Resident #43 dated 3/01/2024 at 1650 (4:50 PM) revealed, .Resident was accepted to [Named Psych Hospital #2] . Review of the Clinical Note for 3/01/2024 at 2058 (8:58 PM) revealed, .Resident transferred to [Named Psych Hospital #2] .Transferred via wheelchair per [Named Transport Service] . Review of the medical record for Resident #43 revealed no documentation for a Bed Hold Form initiated on 3/1/2024. Review of the Clinical Note for Resident #43 dated 7/18/2024 at 12:32 PM revealed, .Pt was transferred approximately 9:30 AM to [named Psych Hospital #2] . Review of the medical records for Resident #43 revealed no documentation for a Bed Hold Form initiated on 7/18/2024. During a telephone interview on 10/17/2024 at 4:50 PM, Power of Attorney (POA) OOOOOO , stated, .I was notified when [Named Resident #43] was sent to [Named Psych Hospital #2] .she was sent out twice, once in March and then again in July . there was no mention of a bed hold policy .don ' t remember getting a bed hold in the mail . During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #43 ' s medical record and acknowledged there was no documentation for Bed Hold Form initiated on 3/1/2024 and 7/18/2024. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses which included Acute Kidney Failure, Metabolic Encephalopathy, and Dehydration. (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Clinical Note for Resident #52 dated 8/5/2024, at 3:30 PM revealed, .patient had labs drawn last week and today results came back with hemoglobin of 6.6, patient was transferred to ER via ambulance approximately 1:50 PM, for blood transfusion per NP . Review of the facility ADT (Admission Discharge Transfer) Report revealed Resident #52 was transferred to a short-term hospital on 8/5/2024 at 12:00 PM. Review of the medical record for Resident #52 revealed there was no Bed Hold Policy initiated on 8/5/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #52 ' s medical record and acknowledged there was no documentation for Bed Hold Form initiated on 8/5/2024. Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses which included End Stage Renal Disease, Anemia, and Atrial Fibrillation. Review of the Clinical Note for Resident #53 dated 8/10/2024 revealed, .During report it was noted that patient had been running a slight fever and not feeling well and he is to be monitored for changes. Patient wife approached the nurse and explained that due to her husband's condition getting worse throughout the evening she wanted to go ahead and send him out to the hospital . Review of the medical record for Resident #53 revealed there was no Bed Hold Policy initiated on 8/10/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #53 ' s medical record and acknowledged there was no documentation for Bed Hold Form initiated on 8/10/2024. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses which included Anoxic Brain Damage, Atrioventricular Block, and Cardiomyopathy. Review of the Clinical Note for Resident #54 dated 9/16/2024 at 6:25 PM for Resident #54 revealed, .This nurse notified that resident was lethargic and eyes were red. This nurse went in and assessed resident and found resident to be lethargic with food in his mouth and unable to respond to sternum rub and pupils were fixed. This nurse then contacted [named NP] to get order to send resident out to ER for further evaluation . 911 was called and report given to send resident to [named Facility #4] for further evaluation . Review of the medical record for Resident #54 revealed there was no Bed Hold Policy initiated on 9/16/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #54 ' s medical record and acknowledged there was no documentation for Bed Hold Form initiated on 9/16/2024. Review of the medical record revealed Resident #51 was admitted to the facility on [DATE] with diagnoses which included Malignant Neoplasm of Brain, Kidney Transplant Status, and Unspecified Convulsions. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Clinical Note for Resident #51 dated 9/23/2024 revealed, .At 11:00 AM notified by nursing personnel that resident didn't ' look right ' obtained vital signs. Skin cool to touch. Oxygen level 77% on room air. Placed on a non-rebreather mask. Notified [named NP]. Resident was sent out via 911 stretcher to Hospital #4 for evaluation. Contact was notified. DON aware . Review of the medical record for Resident #51 revealed there was no Bed Hold Policy initiated on 9/23/2024. During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #51 ' s medical record and acknowledged there was no documentation for Bed Hold Form initiated on 9/23/2024. The DON confirmed the facility was required to provide a Bed Hold Policy to all residents/resident representatives at the time of each transfer.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, and interviews, the facility failed to update the care plan for 2 (Resident #45and #56) of 70 sampled residents reviewed for care plans. The findings included: Review of the facility policy titled, Comprehensive Careplan, with effective date 11/09/2023 revealed, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and time frames to meet a resident ' s medical, nursing .needs that are identified in the resident ' s comprehensive assessment. Our resident person-centered plan of care includes the Comprehensive care plan and the Resident care needs . Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, Nutritional Deficiency, and Gastro-Esophageal Reflux Disease (GERD) without Esophagitis. Review of a Clinical Note for Resident #45 dated 3/27/2024 at 1:21 PM, revealed, .Resident room mate have LICE in her HAIRS. called NP [Nurse Practitioner] and got ordered or LICE KILLING SHAMPOO to use or lice precaution. family notified. Will monitor continue . Review of the Physician Order Sheet for Resident #45 dated 3/28/2024, revealed .Lice Killing 0.33%-4% shampoo in her hair and stay 10-15 minute . Review of the Annual Minimum Data Set (MDS) assessment for Resident #45 dated 8/31/2024, revealed a Brief Interview for Mental Status (BIMS) score of 00 which indicated the resident was unable to complete the interview. Review of the Care Plan for Resident #45 dated 9/5/2023 through 9/11/2024 revealed there was no problem/intervention implemented for actual condition and/or isolation precautions for head lice. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] with diagnoses which included Sepsis, Acute Respiratory Failure, and Encephalopathy. Review of a Clinical Note for Resident #56 dated 3/27/2024 at 1:11 PM revealed, .CNT [Certified Nursing Technician] was giving resident shower observed some LICE in resident HAIR .LICE KILLING SHAMPOO . Resident put on isolation . Review of the Physician Order Sheet for Resident #56 dated 3/28/2024, revealed .Lice Killing 0.33%-4% shampoo in her hair and stay 10-15 minute . Review of the Admission MDS assessment dated [DATE] for Resident #56 revealed, a BIMS score of 10, which indicated moderate cognitive impairment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Comprehensive Care Plan for Resident #56 dated 9/3/2024, revealed there was no problem/intervention implemented for actual condition and/or isolation precautions for head lice. During an interview on 10/21/2024 at 11:25 AM, the MDS Coordinator was asked if head lice with isolation precautions should be care planned. The MDS Coordinator replied, Oh yes. The MDS Coordinator reviewed the medical record for Resident #45 and #56 and acknowledged there were no care plans implemented for isolation precautions and head lice for either resident. During an interview on 10/21/2024 at 11:59 AM, the Director of Nursing (DON) was asked what her expectations were for a resident with head lice. The DON stated, .They should be put on contact isolation . anyone else in the room should be treated and isolated .should be care planned also . The DON reviewed the medical record for Resident #45 and #56 and confirmed there was not a care plan focus for head lice with isolation precautions implemented. The DON stated there should have been care plan interventions for head lice and isolation precautions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on the facility policy review, medical record review, and interviews, the facility failed to provide a resident who was unable to carry out activities of daily living (ADL) the necessary services to maintain personal hygiene for 1 of 5 (Resident #33) residents reviewed for bathing. The findings included: Review of the facility policy titled Activities of Daily Living dated 4/17/2024, revealed .Care and services shall be provided for the following activities of daily living: Bathing, dressing, grooming .A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good .personal .hygiene . Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Therapy, Diabetes Mellitus with Hypoglycemia and Acute Embolism and Thrombosis of Deep Vein. Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #33 .was dependent for . toileting hygiene, personal hygiene and dressing . Resident #33 was dependent for sit to lying, chair/bed to chair transfer, and tub/shower transfer. Review of the Care Plan dated 4/1/2024, revealed . 5/7/2024 Bath/shower 3xweek/prn [as needed] as tolerated alternating days with bed baths .shower more frequently if resident choses .self care deficit R/T ambulation, bathing, bed mobility, dressing, eating, hygiene, locomotion and transfers .at risk for impaired skin integrity . Review of the shower schedule revealed Resident #3 had scheduled showers on Monday, Wednesday and Friday. Review of the ADL Verification Worksheets for Resident #33 dated March 2024 revealed Resident #33 had a bed bath on 3/29/2024 and 3/31/2024. Resident #33 should have received 31 bed baths during the month of March and only received 2 bed baths. Resident #33 was not given a shower during the month of 3/2024. Review of the ADL Verification Worksheets for Resident #33 dated April 2024 revealed Resident #33 had a bed bath on 4/1/2024, 4/3/2024, 4/4/2024, 4/7/2024, 4/8/2024, 4/9/2024, 4/13/2024, 4/14/2024, 4/15/2024, 4/25/2024, and 4/30/2024. Resident #33 should have received 30 bed baths during the month of April and only received 11 bed baths. Resident #33 was not given a shower during the month of 4/2024. Review of the ADL Verification Worksheets for Resident #33 dated May 2024 revealed Resident #33 had a bed bath on 5/2/2024. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33 should have received 31 bed baths during the month of May and only received 1 bed bath. Resident #33 was not given a shower during the month of 5/2024. Review of the ADL Verification Worksheets for Resident #33 dated June 2024 revealed Resident #33 had a bed bath on 6/4/2024, 6/9/2024, 6/15/2024, 6/30/2024. Resident #33 should have received 30 bed baths during the month of June and only received 4 bed baths. Resident #33 was not given a shower during the month of 6/2024. Review of the ADL Verification Worksheets for Resident #33 dated July 2024 revealed Resident #33 had a bed bath on 7/1/2024, 7/7/2024, 7/8/2024, 7/14/2024, 7/16/2024, 7/24/2024, 7/30/2024. Resident #33 should have received 31 bed baths during the month of July and only received 7 bed baths. Resident #33 was not given a shower during the month of 7/2024. Review of the ADL Verification Worksheets for Resident #33 dated August 2024 revealed Resident #33 had a bed bath on 8/2/2024, 8/12/2024, 8/13/2024, 8/14/2024, 8/23/2024, 8/28/2024, 8/31/2024. Resident #33 should have received 31 bed baths during the month of August and only received 7 bed baths. Resident #33 was not given a shower during the month of 8/2024. Review of the ADL Verification Worksheets for Resident #33 dated September 2024 revealed Resident #33 had a bed bath on 9/9/2024, 9/13/2024, 9/14/2024, 9/15/2024, 9/16/2024, 9/23/2024, 9/27/2024, 9/29/2024. Resident #33 should have received 30 bed baths during the month of September and only received 8 bed baths. Resident #33 was not given a shower during the month of 9/2024. Review of the ADL Verification Worksheets for Resident #33 dated October 2024 revealed Resident #33 had a bed bath on 10/3/2024, 10/4/2024, 10/5/2024, 10/6/2024, 10/8/2024, and 10/10/2024. Resident #33 should have received 31 bed baths during the month of October and only received 6 bed baths. Resident #33 was not given a shower during the month of 10/2024. During an interview on 9/19/2024 at 10:26, Family Member (FM) WWW stated Resident #33 smelled sour, did not get nail care and her showers were not being done. During an interview on 10/22/2024 at 11:05 AM, the Director of Nursing (DON) was asked whether the facility had the capability of showering a resident with a tracheostomy and the DON responded yes. The DON reviewed the ADL documentation for Resident #33 and was asked what her expectations were related to ADL documentation. The DON stated the Certified Nursing Assistant (CNA)s should document bathing on a daily basis. The DON confirmed Resident #33 did not have a bed bath documented daily. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/6/2024 at 1:27 PM, CNA L stated, .I used to work at the facility on 7 AM to 7 PM shift .I would have 14 to 15 residents during the day .several residents in the building are a 2 person lift .you spend time looking for equipment and someone to come help you get residents up .you don ' t have time to chart .patients were not getting their baths especially on the weekend .the residents would complain .they can ' t keep anybody because the patients are such a heavy load .they had a staffing person I think she worked like two weeks and quit .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record reviews, and interviews, the facility failed to provide a physician order to administer medication for 2 of 7 residents (Resident #43 and Resident #8) reviewed for physician orders. The findings include: Review of the facility's policy titled, Physician Verbal Order Policy, revised on 4/18/2024 revealed, . Immediately read-back of the orders to the physician or health care provider .Enter the order into the medical record manually or electronically .Write T.O. (telephone order) or V.O. (verbal order), including date, time, name of the resident, the complete order; and sign the name of the physician or health care provider and nurse or sign off the electronic order as per the software system guidelines .physician should sign the order on his/her next visit to the facility or within the time frame required by the facility . Review of the facility's policy titled, Medication Administration, revised on 8/4/2023 revealed, .Medications shall be administered . per the Physician's Signed Order . Review of medical record revealed, Resident #43 was admitted to the facility on [DATE] with a diagnosis which included Unspecified Dementia, Type 2 Diabetes, Anxiety Disorder, and Chronic Kidney Disease. Review of a Clinical Note dated 2/25/2024 at 2:29 AM revealed, .Resident yelling and combative with roommate, removed resident from room .contacted on call physician, orders for Haldol [Medication used to treat nervous, emotional, and mental conditions] 5mg [milligrams] IM [intramuscular] x [times] 1 dose .Haldol effective and resident resting in bed . Review of Physician Order Sheet for Resident #43 dated 2/2024 revealed, no order for Haldol 5mg IM x 1 dose. During an interview on 10/30/2024 at 10:00 AM the Director of Nursing (DON) reviewed Resident #43's medical record and acknowledged there was no order for Haldol 5 mg IM x 1 dose in 2/2024. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses which included Atrial Fibrillation, Hemiplegia, and Altered Mental Status. Review of a Clinical Note for Resident #8 dated 9/15/2024 at 1:11 PM, revealed, .Patient began throwing up around 12:45 pm .PC [phone call] to NP [Nurse Practitioner] who ordered a dose of simethicone [a medication used to treat the symptoms of gas such as uncomfortable or painful pressure, fullness, and bloating] . Review of the Physicians Order Sheet for Resident #8 dated 9/2024 revealed no order for simethicone. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 10/28/2024 at 12:36 PM, the Assistant Director of Nursing (ADON) stated, .If a nurse receives a verbal order from the doctor, it must be put into the computer immediately .All medications given to a patient must have a doctor's order . The ADON stated nursing staff should write the order down on paper, repeat the order back to the provider, enter the order into the computer, print a copy of the order entered into the computer, then place it in a basket at the desk for review by the DON or ADON. During an interview on 11/6/2024 the NP stated nursing staff are required to obtain an order for all resident transfers and all medications to be administered. The NP stated the nurse would put the order into the computer and when notified, the provider will sign the order During an interview on 11/7/2024 at 6:10 PM, the DON reviewed Resident #8's medical record and acknowledged there was no documentation for a physician order for simethicone in 9/2024. The DON confirmed a physician order was required to administer all medications to a resident.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on the facility policy review, medical record review, and interviews, revealed the facility failed to ensure that a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcer for 2 (Resident #31 and Resident #33) of 9 residents reviewed for wound care. The findings include: Review of medical records revealed Resident #31 was admitted to the facility on [DATE] with diagnoses which included Acute Diastolic Heart Failure, Morbid Obesity, and Protein Calorie Malnutrition. Review of the Care Plan dated 2/19/2024, revealed Resident #31 revealed .at risk for malnutrition/hydration/weight loss related to GERD .Morbid Obesity, mechanically altered Diet, Daily Diuretics .risk for impaired skin integrity .weekly skin audits .has Stage 4 pressure ulcer to coccyx .assess size 1 time weekly . Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated no cognitive impairment. Resident #31 requires the use of a wheelchair and had an external catheter and ostomy. Resident #31 has always been incontinent of bowel and bladder. Review of the Wound Assessment Report dated 8/27/2024, revealed Resident #31 had a facility acquired wound discovered on 5/27/2023. The wound was located on Pelvic Girdle/ Buttock which is a stage IV with reported onset date 5/27/2023. The wound assessment report revealed the facility acquired wound was not discovered until it had progressed to a Stage IV pressure ulcer on the coccyx. During an interview on 11/5/2024 at 2:31 PM, when asked at what stage should a resident ' s (Resident #31) wound be diagnosed and she stated the wound should have been discovered prior to becoming advanced to a Stage IV. The Wound Care Nurse stated if the weekly skin audits were being done, they should have been discovered prior to becoming a stage 3. When asked what her expectation are for staff, the wound care nurse responded, she should be notified when there are discolorations in the skin and nursing should be completing weekly skin audits. During an interview on 11/5/2024 at 6:45 PM, the Director of Nursing (DON) stated her expectation are for nursing to complete a full body skin audit weekly on all residents including ambulatory residents as prescribed. The DON also expects Certified Nursing Assistant (CNA)s to do skin checks with showers. The shower sheets are used to identify new or worsened skin concerns which are to be forwarded to the floor nurse, and the floor nurse should make the nurse practitioner or medical physician aware. Any new orders should be passed on to wound care nurse.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38441 Based on policy review, record review, medical record review, observation, and interview, the facility failed to ensure a safe, secure environment for a vulnerable and high-risk resident with wandering behaviors for 1 of 5 sampled residents (Resident #1) reviewed for elopement/wandering. The facility's failure to ensure a safe, secure environment resulted in Immediate Jeopardy (IJ) when Resident #1 exited the facility through the window in his room. Resident #1's sister called the facility around 5:30 AM to notify the facility that Resident #1 was found sitting on her front porch which was approximately 3 miles from the facility, along highly trafficked city streets and in a heavily populated area. Facility staff were unaware Resident #1 had exited the facility for approximately 8 and a half hours. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator was notified of the Immediate Jeopardy (IJ) on 11/7/2024 at 8:05 PM, in the Administrator's Office. The facility was cited Immediate Jeopardy at F-689 at a scope and severity of J, which is Substandard Quality of Care. The IJ began 6/22/2024 through 6/26/2024. The Immediate Jeopardy was removed on 6/27/2024 when the facility implemented a corrective action plan. The corrective actions were validated onsite by the surveyor on 9/9/2024 and 9/10/2024. The facility was cited as past non-compliance and is not required to submit a Plan of Correction. The findings include: Review of the facility's policy titled, Elopements and Wandering Patients, dated 2/5/2024, revealed, .To provide guidance on elopement and residents who exhibit wandering behaviors and/or are at risk for elopement .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk . Elopement occurs when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so .The facility is equipped with door locks/alarms to help avoid elopements. Alarms are not a replacement for necessary supervision .The facility shall establish and utilize a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering, including identification and assessment of risk, Evalution and analysis of hazards and risks, implementing interventions when necessary .Residents shall be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team . Adequate supervision shall be provided to help prevent accidents or elopements . (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Acute Cystitis with Hematuria, Chronic Kidney Disease, Adult Failure to Thrive, Schizoaffective Disorder, Unspecified Convulsions, Dementia, Depression, Repeated Falls, Epileptic Seizures without Status Epilepticus, Muscle Weakness, and Other Lack of Coordination. Review of the Elopement Risk Assessment for Resident #1 dated 4/24/2024, revealed the resident experienced periods of cognitive impairment and/or poor decision-making skills, ambulated independently, and had a history of eloping from home or the facility. A wander guard bracelet was implemented, and Resident #1's care plan was initiated/updated to reflect his elopement risk and the interventions which were implemented. Review of the Psychiatric Evaluation dated 4/29/2024, for Resident #1 revealed .Reports from hospital suggest patient [Resident #1] is an elopement risk .When asked patient [Resident #1] why he was at the facility stated 'I do not know'. Impaired judgement and insight. Patient [Resident #1] showing deficits in his ability to process, abstraction, rationalize information . Review of the Elopement Risk Assessment for Resident #1 dated 5/15/2024, revealed Resident #1 experienced a change in status, cognitive impairment, poor decision-making skills, and ambulates independently. Further review revealed patient made comments about leaving the facility and experienced exit seeking behaviors. Interventions implemented were a wanderguard, diversional activities, care plan initiated and updated to reflect elopement risk and interventions. Resident #1 was given education on the risk of leaving the facility to seek out substance, discharge process including Against Medical Advice (AMA), and Leave of Absence (LOA) process. Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #1 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment, which indicated no cognitive impairment, and the resident sustained a fall within the last month. Resident #1's MDS revealed no wandering or behaviors. Review of the undated Comprehensive Care Plan for Resident #1 revealed, .Confusion, alteration, in thought process related to [Named Resident #1] had dementia .[Named Resident #1] has exhibited Wandering Behavior .Wander guard on Rt [right] ankle .Record behaviors on Behavior Tracking Form .Use wander guard/location monitor daily .6/23/24 [2024] Elopement: verified resident locate [location] and physical assessment and transferred [to] another facility .Observe for changes in behavior, altered mental status, sudden change in cognitive function, orientation, and/or communication .5/28/24 [2024] Resident prefer [prefers] to sleep on bathroom floor . Review of a Physician's Order for Resident #1 dated 5/15/2024, revealed .Wander guard. Notes: Montior [monitor] placement of wander guard (RLE) [right lower extremity] . Review of a Physician's Order for Resident #1 dated 5/15/2024, revealed .Wanderguard Function Test. Notes: Check function daily using 707 tester [system to check wander guards] . Review of a Progress Note for Resident #1 dated 5/15/2024, revealed .Updated elopement/wandering assessment completed. The resident [Resident #1] presents as an elopement risk due to wandering and exit seeking behaviors. Wander guard initiated, placed to RLE .RP [Responsible Party] made aware . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of a Provider Progress Note for Resident #1 dated 5/24/2024, revealed .History of behavioral disturbances and elopement risk . Review of the June 2024 Treatment Administration Record (TAR) for Resident #1 revealed on 6/22/2024 Resident #1's wander guard was checked twice and tested on ce per orders. Review of the Investigation Summary dated 6/23/2024, revealed .Report Received: 6/23 [6/23/2024] reported by [Named Assistant Director of Nursing (ADON)] .Type of Allegation Elopement .Detailed Description of Allegation: Sometime during the night resident [Resident #1] left his room via [by way of] his window. Window was raised and he exited the building going to his sister's house. When his brother in law left the house at 5:40 AM, he saw [Named Resident #1] sitting on porch. He [Resident #1's brother in law] notified his wife that her brother was sitting on [the] porch. She [Resident #1's sister] notified nursing home and made arrangements to return him at 10:00 AM .The allegations were verified . Review of the Nurse's Event Note by the ADON dated 6/23/2024, revealed .Description: Elopement .No apparent injury .Received call from nurse stating [Resident #1] had exited the facility via window. The nurse was notified by the resident's sister . [Resident #1] was sitting on her front porch. The sister was laughing and said he had a history of doing this .[Resident #1] was transferred to secured facility . During an interview on 9/5/2024 at 11:02 AM, Family Member (FM) A stated, .[Named Resident #1] was a high elopement risk and had an ankle monitor. [Named Resident #1] climbed out the window sometime during the night. [Named Resident #1] didn't have his monitor on when he got to my house, and I don't know when he took it off. I found [Named Resident #1] at my house on the porch sometime after 5 [5:00] AM. The weather that morning was hot, and my brother was dressed appropriately for the weather. The facility didn't know he was at my house. [Resident #1] was missing from about 8 [8:00] PM to when I called the facility after 5 AM from what I was told. I was told by one of the nurses that [Named Resident #1] was last seen in the facility around 8:00 PM. The ADON came by my house and spoke with my brother. My brother said he wanted to leave which is why he left through the window. My brother has a history of wanting to leave and has left family member's houses before. Nobody knew [Named Resident #1] was gone until I called. I live about 3 miles from the facility. The facility did speak with me about transferring [Named Resident #1] to another facility that could provide him with a higher level of care. [Named Resident #1] was sent to another facility that had a lockdown unit . During an interview on 9/5/2024 at 4:12 PM, the Life Enrichment Director stated, .Usually I add resident names outside the room when they first come. If it's late at night, then I do it first thing in the next morning. If it is a weekend, then the name would be placed on the room the following Monday. [Named Resident #1]'s name was not outside his room. [Named Resident #1] was sent out for a period of time and when he came back, he was put in different room. [Named Resident #1]'s original room was [named room on the 500 hall] and his name was on that room but when he came back, he was put in room [named Resident #1's room also on the 500 hall]. Normally, the nurses would just switch the name tag to the new room. I'm not sure why his name didn't get switched. I guess it was just an oversight . (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/6/2024 at 10:13 AM, Licensed Practical Nurse (LPN) I stated that Resident #1 normally slept in bathroom on the floor. LPN I explained she went in Resident #1's room during her first medication pass around 8:00 PM/9:00 PM and spoke with the [Resident #1]. He did not want to sleep in his bed. LPN I stated, .I didn't go back to his room after that because he didn't receive morning medications. LPN I was asked how often staff should do rounds on the residents. LPN I stated the CNA assigned to him [Resident #1] should have made rounds every 2 hours. LPN I stated, .I went back to [Resident #1]'s room after I received a phone call that he was not in the building, and the window was open .the CNA assigned to [Resident #1] did not go back in his room to check on him during her shift .the windows could open all the way, but now the windows only open about 6-8 inches . During an interview on 9/6/2024 at 10:58 AM, the Director of Nursing (DON) stated that she expects staff to do rounds on residents at least every 2 hours at a minimum. During an interview on 9/6/2024 at 11:04 AM, Certified Nursing Assistant (CNA) H stated, .I came to work at around 7:00 PM that night. I was assigned the 500 Hall minus room [Resident #1's room]. I am unsure if it said minus [bed A or bed B. I just remember it saying minus [Resident #1's room]. I did my first rounds from 7 [7:00] PM-11 [11:00] PM. I opened the door to room [Resident #1's room], and there was no name on the door, and the room was empty. I didn't go back to that room on my second round because no one was in there when I did my first rounds. I didn't know that someone was supposed to be in that room until I was told that morning that [Named Resident #1] had eloped . During an interview on 9/6/2024 at 2:58 PM, LPN L stated, .[Named Resident #1] didn't have a roommate. I didn't work with him that night. He [Resident #1] liked to sleep in the bathroom. He [Resident #1] did have a wander guard. The windows in the facility are usually closed at night, but [Named Resident #1] did have the mental and physical capacity to unlock and open the window if he wanted to . During an interview on 9/6/2024 at 3:15 PM, CNA K stated the last time she saw Resident #1 was around 7:30 PM or 8:00 PM. CNA K stated Resident #1 was in the hallway. CNA K was asked how often are CNAs expected to do their rounds. CNA K stated staff are expected to do their rounds every 2 hours. During an interview on 9/9/2024 at 10:44 AM, the Maintenance Director stated, .New locks were ordered for the windows after the elopement. The windows were going to be secured to open no more than 8 inches. In morning meeting, it was brought up that all the windows could open all the way so that's when we were told to put the blocks in the windows. The window blocks were ordered on 6/23/2024 and arrived the next day which was Monday 6/24/2024. The window blocks were installed into each residents' room window and require a specialty tool called an[named] key to install and remove if needed. Until the window blocks arrived, we were required to do 2 hour checks on the windows . Observations on 9/9/2024 by surveyor a nd administrator for window checks for the window blocks are as follows: 4:15PM 200 Hall all windows secured to 8inches when opened 4:27PM 700 Hall all windows secured to 8inches when opened 4:42PM 600 Hall all windows secured to 8inches when opened 4:53 PM 500 Hall all windows secured to 8inches when opened (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5:07 PM 400 Hall all windows secured to 8inches when opened 5:19 PM 300 Hall all windows secured to 8inches when opened During an interview on 9/9/2024 at 12:56 PM, the ADON stated, .I went to the sister's home to see [Named Resident #1] make sure he was okay. I received a call at home that a patient [Resident #1] left the facility. [Resident #1] had no reported exit seeking behavior that day because I would have been made aware of it. [Named Resident #1] had a habit of sleeping in the bathroom on the floor with the door closed . The ADON was asked how often is staff supposed to do rounds on residents. The ADON stated, .Staff are supposed to round Q [every] 2 hours or as much as possible. We don't require documentation of CNA doing rounds unless they report an issue to the nurse on duty . The ADON was asked if the CNA that was assigned to Resident #1 conducted her rounds that night. The ADON stated, I would think that she would have. The ADON was asked if rounds were being conducted should someone have noticed that Resident #1 was not in the facility. The ADON stated, .Sometimes [Named Resident #1] would sleep in the bathroom with the door closed so you may not see him in there . The ADON was then asked would that need to be something that was on Resident #1's care plan so that new staff would know to check the bathroom if resident needed to be located. The ADON stated, .Yes, that would need to be something that was on the care plan The ADON confirmed this was not addressed on Resident #1's care plan. During an interview on 9/9/2024 at 2:37 PM, the Maintenance Assistant stated, .The administration had me put new window blocks in the very next day in every room. We had to check the windows every 2 hours until the block came in the next day (6/24/ 2024) . During an interview on 9/10/2024 at 2:47 PM, CNA P stated, .I did provide care to [Named Resident #1] on 6/22/2024. [Named Resident #1] was in the building during my 7 [7:00] AM-7 PM shift. [Named Resident #1] didn't have any exit seeking behaviors that day and didn't mention anything about leaving. [Named Resident #1] liked to sleep in his bathroom on the floor but would come out for meals. I did give a verbal report to the oncoming CNA, but I don't remember the CNA's name. I did let the oncoming CNA know that [Named Resident #1] was in the bathroom . The facility's corrective action plan included the following: 1. 6/23/2024 facility conducted a check to make sure all residents in the building were accounted for. 2. 6/23/2024-6/24/2024 100% (percent) elopement assessments conducted for all residents. 3. 6/23/2024 window checks conducted every 2 hours. 4. 6/23/2024 100% wander guard placement and checks completed. 5. 6/26/2024 100% audit for name tag outside door. 6. 6/23/2024 residents with a BIMS 12 or higher were interviewed regarding their care. 7. 6/26/2024 Body Audits were conducted on resident with a BIMS under 12. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	8. 6/23/2024 Governing Body call was held to discuss elopement. 9. 6/24/2024 ADHOC (meeting conducted for a particular purpose) QAPI (Quality Assurance Performance Improvement) Meeting was held to address elopement. 10. 6/24/2024 Behavior Meeting was held to go through behavior log to ensure all behaviors have been documented and care planned. 11. Elopement Drills occurred on 6/24/2024, 6/26/2024, 7/3/2024, 7/4/2024, 7/10/2024, 7/18/2024, 7/25/2024, and 7/29/2024. 12. Elopement/Wandering, Rounding, and Abuse Trainings were conducted on 6/23/2024 and is ongoing. 13. Weekly Audits for Staff Education Weekly and Maintenance logs from June 2024-September 2024.

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on facility job description, facility policy review, ADL (Activities of Daily Living) Verification Worksheet, Patient Weight Reports, Weight (wt) Loss Documentation Report, medical record review, observation and interview, the facility failed to recognize repeated, systemic failures to assess and address a resident ' s nutritional status and to implement pertinent interventions that resulted in continued significant weight loss for 5 of 9 (Residents #67, #65, #63, #45 and #46) sampled residents reviewed for nutritional needs. Resident #45 experienced a significant weight loss of 10% (percent) in 6 months. Resident #67 suffered a significant and severe weight loss of approximately 9.0% over 2 months from 8/15/2024 to 10/14/2024. Resident #65 suffered a significant and severe weight loss of approximately 8.5% over 1 month from 8/9/2024 to 9/13/2024. Resident #63 suffered a significant and severe weight loss of approximately 10.19% over 3.5 months from 2/5/2024 to 5/20/2024. Resident #45 suffered a significant weight loss of approximately 5.0% over 1.6 months from 2/5/2024 to 3/25/2024. Resident #46 suffered a significant and severe weight loss of approximately 13.5% over 1.5 months from 12/9/2023 to 1/23/2024. Repeated failure to assist vulnerable residents with meals and fluid intake and failure to document meal intake contributed to the continuation of a severe decline in the nutritional status. The facility failed to assist Residents #67, #65, #63, #45 and #46 with meals and/or record food intake percentages with each meal. The facility ' s failure to assess nutritional status, assist residents with meals, and monitor meal intakes resulted in significant and severe weight loss for Resident #67, #65, #63, #45 and #46 which resulted in Immediate Jeopardy (IJ), a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death to a resident. The Administrator was notified of the Immediate Jeopardy on 11/6/2024 at 1:15 PM in the Administrator's office. The facility was cited at F-692 with a scope and severity of K, which is Substandard Quality of Care. The Immediate Jeopardy began on 1/9/2024 and is ongoing. A partial extended survey was conducted on 10/21/2024 to 11/7/2024. The facility is required to submit a Plan of Correction (POC). The findings include: 1. Review of the Job Description for Certified Nurse Aide (CNA) dated 8/20/2021, revealed .ESSENTIAL JOB DUTIES .Recognize and respond to the needs of residents .Report and record resident ' s intake on meal percentage sheets and report to charge nurse intake of less than 25% . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Job Description for the Regional Registered Dietician (RD) dated 8/20/2021, revealed .The Regional Registered Dietician is to provide clinical expertise through assessment of patients utilizing Medical Nutrition Therapy .ESSENTIAL JOB DUTIES .Assess individual patients regarding appropriate nutritional care in compliance with state and federal regulations .Conduct rounds, audit medical records to determine facility compliance with state and federal guidelines .Review quality initiative data . 2. Review of the facility policy titled, Dietary: Weight Monitoring, dated 11/9/2023, revealed .Based on the resident ' s comprehensive assessment, the facility shall ensure that all residents maintain acceptable parameters of nutritional status .If nutritional goals are not achieved, care planned interventions shall be reevaluated for effectiveness and modified as appropriate .Weight Analysis .5% change in weight in 1 month (30 days) .7.5% change in weight in 3 months (90 days) .10% change in weight in 6 months (180 days) . Review of the facility policy titled, Activities of Daily Living, dated 4/17/2024, revealed .Eating to include meals and snacks .A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition . 3. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses which included Unspecified Systolic (Congestive) Heat Failure, Dysphagia (difficulty swallowing), Oral Phase, and Anorexia Nervosa. Review of the Annual Minimum Data Set (MDS) assessment for Resident #67 dated 1/25/2024, revealed a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. Continued review revealed setup or clean-up assistance with eating. Review of the care plan for Resident #67 dated 1/30/2024, revealed .2/13/2024 .At risk for malnutrition related weight loss .Monitor meal intake and offer substitute if resident eats less than {*} [no specific percentage indicated] % of meal .8/29/2024 .At risk for weight loss and malnutrition/related to receiving mechanically altered diet, diagnosis of adult failure to thrive .At risk for malnutrition/hydration deficit .Monitor meal intake and offer substitute if resident eats less than 50% of meal .Self care deficit R/T [related to] . eating .Eating-Encourage .to eat all meals in Dining Room as tolerated .Assist with eating as needed . Alteration in nutrition/hydration R/T Receives daily Diuretic and Ages related cognitive decline .Monitor food intake at each meal .Document % [percent] eaten .Offer water with each medication pass . Review of Resident (Res) #67 ' s Patient Weight Report dated 8/15/2024 through 10/14/2024, revealed: 8/15/2024: 142.0 lbs (pounds). 8/20/2024: 139.2 lbs; 9/16/2024: 138.0 lbs; 10/14/2024: 129.2 lbs. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #67 suffered a significant and severe wt loss of approximately 9.0% over 2 months from 8/15/2024 to 10/14/2024. Resident #67 lost a total of 12.8 lbs in 2 months. Review of the ADL verification worksheet for Resident #67 dated 8/15/2024 through 10/14/2024, revealed of the 180 meals delivered, 101 meals had no documentation of the percentage of total meal consumption. (56. 11% of meal percentages were not documented) Review of the facility ' s Clinical Notes Entry for Resident #67 dated 9/23/2024, the RD documented, . inconsistent intake noted . Review of the facility ' s Progress Note for Resident #67 dated 10/23/2024 at 11:48 AM, the RD documented, .Res with sig [significant] wt loss x [times] 1 month .Wt down-10# [pound] in 1 month noted .Poor meal intake . Review of the facility ' s Weight Change Assessment for Resident #67 dated 10/24/2024, revealed the Director of Nursing (DON) documented .Previous Weight .138 .Current weight .129.2 .Weight change Percentage .6.3 .Weight Change in Pounds .8.8 .Timeframe for WT change .30 Days . 4. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE] with diagnoses which included Metabolic Encephalopathy, Failure to Thrive, Unspecified Dementia, Dysphagia, Oropharyngeal Phase, and Failure to Thrive. Review of Resident #65 ' s Patient Weight Report dated 8/9/2024 through 9/13/2024, revealed: 8/9/2024: 114.6 lbs. 8/23/2024:112.8 lbs. 8/28/2024: 110.0 lbs. 9/13/2024: 104.8 lbs. Resident #65 suffered a significant and severe weight loss of approximately 8.55% over 1 month (35 days) from 8/9/2024 to 9/13/2024. Resident #65 lost a total of 9.8 lbs. in 1 month. Review of the ADL verification worksheet for Resident #65 dated 8/9/2024 through 9/13/2024, revealed of the 105 meals delivered, 78 meals had no documentation of the percentage of total meal consumption. (74. 29 % of meal percentages were not documented) Review of the Annual MDS assessment for Resident #65 dated 8/13/2024, revealed a BIMS score of 11 which indicated moderate cognitive impairment. Continued review revealed Resident #65 required setup or clean-up assistance for eating. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan for Resident #65 dated 8/29/2024, revealed .8/12/24 [2024] slow decline of wt . 8/29/2024 .At risk for weight loss and malnutrition/related to receiving mechanically altered diet, diagnosis of adult failure to thrive .Dietary supplements as ordered .Monitor meal intake and offer substitute if resident eats less than 50% of meal .Offer between meal snacks .10/14 [2024] supplement order .receiving mechanically altered diet .Record food intake at each meal; offer appropriate substitutes for uneaten food . Review of the laboratory (lab) report for Resident #65 from Lab #1 dated 8/23/2024, revealed .ALBUMIN .3. 4(L) . Review of the facility ' s Weight Change Assessment for Resident #65 dated 9/23/2024, revealed LPN FFFFFF documented .Previous Weight .117 .Current Weight .104 .Weight Change Percentage .11.0 .Weight Change in Pounds .13 .Timeframe for WT change .30 Days 90 Days 180 Days . Review of the facility ' s Clinical Note Entry for Resident #65 dated 10/14/2024, revealed .Double portions added to meals . Observation in Resident #65 ' s room beginning on 10/24/2024 at 11:50 AM, revealed the following: Resident #65 ' s lunch tray was delivered to the resident ' s room by CNA GGGGGG. Resident #65 was seated in a wheelchair with the bedside table over her lap. CNA GGGGGG prepared the tray (opened the drink, dessert and silverware packet) for Resident #65 and left the room. Resident #65 attempted to pick up her drink unsuccessfully. Resident #65 leaned over her tray and placed her mouth over the straw. After two attempts, Resident #65 was unable to scoop lasagna onto the fork and reach her mouth. Resident #65 ate two bites of a roll and one serving of ice cream. At 12:05 PM, CNA GGGGGG returned to Resident #65 ' s room to collect the lunch tray. CNA GGGGGG was asked how much of the meal Resident #65 ate. CNA GGGGGG stated, . I would say about 25% . CNA was asked how the meal intake would be documented. CNA GGGGGG stated, .I write the intake down on a piece of paper and pulled the paper from her pocket to show this surveyor. CNA GGGGGG was asked if the meal intake was documented in Resident #65 ' s medical record. CNA GGGGGG stated, .No, I ' m not able to document in the record, I don ' t have access . CNA GGGGGG was asked if Resident #65 ' s meal intakes were reported to the nursing staff. CNA GGGGGG stated, .If the nurse asks me how much a resident eats [residents eat], I ' ll tell them. CNA GGGGGG was asked if Resident #65 required assistance with eating. CNA GGGGGG stated, .[Resident #65] only needs her tray set up, she can feed herself . CNA was asked how to identify if a resident needs assistance with eating. CNA GGGGGG stated, .I just ask somebody, a nurse or another CNA . Resident #65 was not offered an alternative meal or encouraged to eat by CNA GGGGGG. The surveyor ' s assessment of Resident #65 ' s lunch tray revealed approx. 10 % of the meal was eaten by Resident #65. No meal ticket was observed on the lunch tray. Observation in Resident #65 ' s room on 10/29/2024 at 6:18 PM, revealed a dinner tray with < (less than) 10% of the food consumed by Resident #65. There was no evidence Resident #65 was assisted with dining. No double portions were on the tray as observed on the meal ticket. Observation in the hallway by the kitchen on 10/31/2024 at 8:20 AM, revealed Resident #65 ' s breakfast tray was delivered back to the kitchen with < 10% of meal consumed. During an interview on 11/1/2024 at 10:05 AM, the MDS Coordinator confirmed Resident #65 had not been care planned for a significant weight loss nor did the facility follow the care plan to record food intake at each meal. (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/1/2024 at 10:10 AM, the DON acknowledged there was no care plan related to Resident #65 ' s significant weight loss. The DON also acknowledged food intake was not recorded at each meal per the care plan. When asked what the expectations were for a significant weight loss, the DON stated, It should have been care planned. Observation in the hallway by the kitchen on 11/5/2024 at 8:40 AM, revealed Resident #65 ' s tray was returned to the kitchen with less than 25% of breakfast eaten. Observation in Resident #65 ' s room on 11/6/2024 beginning at 12:03 PM, revealed Resident #65 was noted sitting up in her wheelchair in the room. Her tray had just been set up. The drink, dessert and silverware packet were opened. Surveyor watched Resident #65 pick up her fork, put a small bite of casserole in her mouth, and eat it. A few minutes later, Resident #65 used her fork to eat her dessert. Resident #65 took a small sip of her drink by leaning over her bedside table. No one came back to help assist Resident #65 with her food or offer her a substitute. Staff did nothing to help Resident #65 in any way. As lunch trays were picked up from the 200 Hall, none of the CNA ' s offered an alternative or encouraged Resident #65 to eat more of her food. Resident #65 consumed less than 10% of lunch. No meal ticket was observed on the lunch tray. 5. Review of the medical record revealed Resident #63 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Heart Failure, and Dysphagia (difficulty swallowing), oral phase. Review of Resident #63 ' s Patient Weight Report dated 2/5/2024 through 5/20/2024, revealed: 2/5/2024: 157.0 lbs. 3/4/2024: 157.5 lbs. 4/30/2024:143.8 lbs. 5/6/2024: 145.0 lbs. 5/13/2024: 143.0 lbs. 5/20/2024: 141.0 lbs. Resident #63 suffered a significant and severe weight loss of approximately 10.19% over 3.5 months from 2/5/2024 to 5/20/2024. Resident #63 lost a total of 16 lbs in 3.5 months. Review of the ADL verification worksheet for Resident #63 dated 2/5/2024 through 5/20/2024, revealed of the 315 meals delivered, 249 meals had no documentation of the percentage of total meal consumption. (79. 05% of meal percentages were not documented) Review of the facility ' s Weight Loss Assessment for Resident #63 dated 5/5/2023, revealed the ADON documented .Previous weight .155.6 .Current Weight .144.5 .Weight change Percentage .7.1 .Weight Change in Pounds .-11.1 .Timeframe for WT change .30 Days . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Quarterly MDS assessment for Resident #63 dated 10/20/2023, revealed a BIMS score of 9 which indicated moderate cognitive impairment. Continued review revealed Resident #63 required setup or clean-up assistance. Further review of the MDS revealed Resident #63 was changed to partial/moderate assistance for eating on 7/14/2024 with a BIMS score of 7, which indicated severe cognitive impairment on the Quarterly MDS. Review of the lab results for Resident #63 from Lab #1 dated 4/11/2024, revealed .ALBUMIN .3.2 (L) [low] . Review of Resident #63 ' s Patient Weight Report dated 4/30/2024, revealed a weight of 143.80 lbs. Review of the facility Clinical Note Entry for Resident #63 dated 5/3/2024 at 8:37 AM, revealed the RD documented, .Res with sig wt loss at 3 months .CBW [Calculated Body Weight] 143.8# .intake ranges from 25-100% .Partial/moderate assistance with meals noted . Review of the care plan for Resident #63 dated 10/29/2024, revealed .10/13/2023 .At risk for weight loss and malnutrition due to receiving dysphagia level 1 diet .Monitor meal intake and offer substitute if resident eats less than {*}% [no percent present] of meal .Encourage .to eat all meals in Dining Room as tolerated . 9/1/2024 .receiving mechanically altered diet .Monitor and document weight .Record food intake at each meal; offer appropriate substitutes for uneaten food .Requires assistance with meals . During an interview on 11/1/2024 at 10:05 AM, the MDS Coordinator confirmed Resident #63 had not been care planned for a significant weight loss nor did the facility follow the care plan to record food intake at each meal. During an interview on 11/1/2024 at 10:10 AM, the DON acknowledged there was no care plan related to Resident #63 ' s significant weight loss. The DON also acknowledged food intake was not recorded at each meal per the care plan. When asked what the expectations were for a significant weight loss, the DON stated, It should have been care planned. During an interview on 11/1/2024 at 11:11 AM, the RD was asked about weight loss on Resident #63. The RD stated, .He [Resident #63] had a significant weight loss at 3 and 6 months of about 11% .he had a weight loss in May 2024 of 10 lbs . During a telephone interview on 11/6/2024 at 10:20 AM, the RD was asked to elaborate on Resident #63 ' s severe weight loss at 3 and 6 months. The RD stated Resident #63 had experienced severe weight loss of 11.6% on 3/4/2024 at 3 months and another severe weight loss of 11.6% on 12/6/2023. When asked if labs should have been taken with a severe weight loss, the RD stated, .Yes .at 3 and 6 months . Continued interview revealed Resident #63 ' s last lab was taken on 1/23/2024. 6. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, Nutritional Deficiency, and Gastro-Esophageal Reflux Disease (GERD) without Esophagitis. Review of Resident #45 ' s Patient Weight Report dated 2/5/2024 through 3/25/2024, revealed: 2/5/2024: 201.2 lbs; (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3/12/2024: 194.0 lbs; 3/19/2024: 194.0 lbs; 3/25/2024: 189.8 lbs. Resident #45 suffered a significant weight loss of approximately 5.0% over 1.6 months from 2/5/2024 to 3/25/2024. Resident #45 lost a total of 11.4 lbs in 1.6 months. Review of the ADL verification worksheet for Resident #45 dated 2/5/2024 through 3/25/2024, revealed of the 147 meals delivered, 113 meals had no documentation of the percentage of total meal consumption. (76. 87% of meal percentages were not documented) Review of Hospital #2 records for Resident #45 dated 3/23/2024, revealed .Critically ill .admitted to the ICU [Intensive Care Unit] due to obtundation [a stated of reduced alertness or consciousness] and hypotension [decreased blood pressure] .received 2 L [liters] of fluid .had admission in January where she presented with decreased mental status and hypotension .felt to be secondary to dehydration .presented similarly during her last admission with altered mental status that seemed to improve with hydration .admission in November 2022 .very similar presentation . Review of the Annual MDS assessment for Resident #45 dated 8/31/2024, revealed a BIMS score of 00 which indicated the resident was unable to complete the interview. Continued review revealed Resident #45 was dependent for eating. Review of the Care Plan for Resident #45 revealed, .Weight loss; 5% or more in last 30 days or 10% or more in last 180 days .4/12/23 [2023]- 5% SWL [Significant Weight Loss] x 30 days .9/11/2024 .Self care deficit R/T [related to] .eating .At risk for malnutrition R/T Vascular Dementia, Alzheimer's, GERD [Gastroesophageal Reflux Disease] .Alteration in nutrition/hydration R/T dx [diagnosis] of Nutritional deficiency .At risk for behaviors r/t Cognitive loss, alteration in thought process related to [Resident #45] demonstrates modified impaired in cognitive skills for daily decision making related to Alzheimer's, depression, and vascular dementia with behavioral disturbance . Review of (named Facility #1) ' s Lunch ticket for Resident #45 dated 10/25/2024, revealed .Assist W [with]/Meals . During a telephone interview on 10/17/2024 at 12:15 PM, the RD was asked about weight loss for Resident #45. The RD stated on 11/10/2023, Resident #45 was 213 lbs, 12/23/2023 at 207.2 lbs, 2/5/2024 at 201.2 lbs, and 3/25/2024 at 189.8 lbs. Resident #45 had a significant weight loss of 10.6% at 6 months. When asked about meal percentages, the RD stated Resident #45 ate 50-75% of meals per documentation. During a telephone interview on 10/19/2024 at 9:33 AM, Family Member (FM) AAAAA stated Resident #45 required total assistance with eating. She stated Resident #45 had been hospitalized three times for dehydration due to staff not offering her water (Resident #45 was unable to ask or pick up a water pitcher herself). FM AAAAA stated Resident #45 had not been feed any meals one day until she arrived to bring food and feed her. She stated the agency CNA (could not remember a name) was not aware that Resident #45 required assistance for feeding. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 10/19/2024 at 10:10 AM, CNA BBBBB stated Resident #45 did not always get fed when agency staff would take care of her. When asked if staff would offer Resident #45 something to drink, CNA BBBBB stated, .The agency staff don ' t always know who requires assistance with meals .they don ' t know she [Resident #45] can ' t get the pitcher and drink herself if no one tells them . During an interview on 10/21/2024 at 10:45 AM, CNA KKKK was unaware that meal percentages less than 25% must be reported to the nurse per the CNA job description. During an interview on 10/21/2024 at 10:50 AM, CNA GGGGG was asked when a meal percentage should be reported to the nurse. She stated, If a patient goes 2 days without wanting to eat, I report to the nurse. When asked if less than 25% eaten by a resident should be reported to the nurse, CNA GGGGG stated, No. They have never told me any specific percentage to report to the nurse. During an interview on 10/21/2024 at 10:55 AM, CNA HHHHH was asked if administration had ever discussed meal percentages less than 25% needed to be reported to the nurse and she stated, No. During an interview on 10/21/2024 at 4:02 PM, Licensed Practical Nurse (LPN) EEEE was asked if Resident #45 or any resident had ever missed being fed a meal. He stated, Maybe and that staff probably needed to monitor this more often. When LPN EEEE was asked how agency staff would be made aware of the needs of a resident, LPN EEEE stated he had told them at times but could not say he did this all the time. During a telephone interview on 10/28/2024 at 3:54 PM, the RD stated Resident #45 was dependent for meals. When asked how she (RD) made recommendation for meals and fluid intake, the RD responded that she based the recommendations on facility documentation. The RD was then asked to look back at the meal percentages documentation and confirm the missed documentation. The RD stated the meal intake documentation had been an issue and was insufficient. Continued interview revealed the RD had addressed her concern with incomplete meal percentage documentation, but documentation was still not being completed. During an interview on 10/29/2024 at 10:01 AM, LPN EEEE stated Resident #45 required total assistance and was an assisted diner. When asked how meal intakes were monitored, LPN EEEE stated, .The CNA ' s put the information in the Kiosk but he did not check to see if it was actually there . During an interview on 10/29/2024 at 11:20 AM, DON acknowledged missed documentation for meal percentages and fluid intake 11/2023 to 10/2024 for Resident #45. When asked if Resident #45 had ever not been fed, the DON stated she was unable to confirm the resident was fed due to the missed documentation. Further interview revealed the DON ' s expectation for meal percentages and fluid intake was to be documented for breakfast, lunch, and dinner daily. Observation of Resident #45 ' s tray on 10/29/2024 at 6:25 PM, revealed Resident #45 ate less than 25% for dinner and drank no fluids. Resident #45 ' s food was barely touched, and the lids remained in place on the drinks. During an interview on 11/6/2024 at 10:20 AM, the RD stated Resident #45 had a 10% weight loss on 3/27/2024 at 6 months that started on 9/13/2023. Between this time, Resident #45 triggered for a slow weight decline on 12/20/2024. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/1/2024 at 10:05 AM, the MDS Coordinator confirmed Resident #45 had not been care planned for a significant weight loss. Continued interview revealed the MDS Coordinator also acknowledged Resident #45 was listed as dependent with eating/dining on the MDS and as assist on the care plan. During an interview on 11/1/2024 at 10:10 AM, the DON acknowledged there was no care plan related to Resident #45 ' s significant weight loss. When asked what the expectations were for a significant weight loss, the DON stated, It should have been care planned. Review of the medical record revealed Resident #58 (Resident #45 ' s roommate) was admitted to the facility on [DATE] with diagnoses which included Atherosclerosis of native arteries of other extremities with ulceration, Osteomyelitis, and Non-pressure chronic ulcer of other part of left foot with unspecified severity. Review of the Admission MDS assessment for Resident #58 dated 8/24/2024, revealed a BIMS score of 15 which indicated no cognitive impairment. During an interview on 10/22/2024 at 12:07 PM, Resident #58 was asked if she had ever witnessed staff offering or assisting Resident #45 with any fluids to drink. Resident #58 stated when she was in the room, she did not observe staff offer anything to Resident #45. She stated, .When she [Resident #45] does get something to drink, she gulps it down because she is so thirsty . Resident #58 was then asked if she witnessed staff assisting Resident #45 with meals. Resident #58 stated Resident #45 was not fed dinner one day and the night shift (7 PM-7 AM) nurse (unknown) came in and fed her. Trays for Resident #45 ' s hall were scheduled to come to the floor at 5:35 PM. During an interview on 10/29/2024 at 12:10 PM, Resident #58 was asked if staff had offered Resident #45 water any time they came into the room. Resident #58 stated, .Not that I have seen .They still don ' t offer her anything to drink when I am in the room . During an interview on 10/22/2024 at 12:13 PM, CNA IIIII stated she was unable to access the Kiosk to view the resident care plan and ADL needs. When asked how she knew what kind of needs a resident required, CNA IIIII stated she had to ask another staff member about each resident when she did not receive report. During an interview on 10/22/2024 at 12:40 PM, CNA KKKKK was asked where to go into the Kiosk to find out what type of care each resident required. CNA KKKKK stated she did not have access to login into the Kiosk. CNA KKKKK was then asked how she documented meal percentages and other information, and she stated, .Under someone else ' s name . During an interview with the RD on 11/1/2024 at 11:11 AM, this surveyor noticed 2 clear bags with meal tickets in them labeled, Residents who did not get fed .10/25/2024 and 10/26/2024 . When asked about the 2 clear bags, the RD stated, .The Dietary Manager just reported this to me .I am going to look at them while I am in the facility . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 11/1/2024 at 11:20 AM, the Dietary Manager (DM) was asked about the 2 clear bags lying on the desk with meal tickets in them. The DM stated, .I was working the dish line and noticed some of the breakfast trays had not been touched .the food was untouched, and the juice still had the lids on them .I decided to keep the meal tickets that were on these trays . During an interview on 11/4/2024 at 8:42 AM, Dietary Aide (DA) BBBBBB stated there were trays that would come back to the kitchen untouched. DA BBBBBB was asked to elaborate on what he meant by untouched. He stated that the tops remained intact on the juice and the food was not touched (unstirred). Continued interview revealed when asked how many times untouched trays came back to the kitchen, DA BBBBBB stated, All the time. 7. Review of medical record revealed Resident #46 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included Cerebral Infarction, Dementia with severe Psychotic Disturbance and Type II Diabetes Mellitus. Review of the Care Plan dated 11/16/2023, revealed Resident #46 had goals and interventions which included .11/16/2023 at risk for malnutrition .Allow adequate time to eat; provide cues; encouragement, and assistance .Dietary Supplements as ordered .Monitor meal intake and offer substitute if resident eats less than 75% .Monitor and encourage fluids and notify MD [Medical Director] if inadequate fluid taken .Dietary Consult as needed .incontinence will be managed by staff without evidence of skin breakdown .has a Stage 2 ulcer to coccyx . Review of the admission MDS dated [DATE], revealed Resident #46 had a Brief Interview for Mental Status (BIMS) score of 1 which indicated severe cognitive impairment. Resident #46 required set up assistance with eating, had no concerns related to nutrition, had an unhealed pressure ulcer/injury at a stage 2. Review of Resident #46 ' s Patient Weight Report dated 12/9/2023 through 1/23/2024, revealed: 12/9/2023: 162 lbs; 1/2/2024: 145.3 lbs; 1/9/2024: 148.0 lbs; 1/16/2024: 144.0 lbs; 1/23/2024: 140.0 lbs. Resident #46 suffered a significant and severe weight loss of approximately 8.64% over 1 month from 12/9/2023 to 1/9/2024. Resident #46 lost a total of 14 lbs in 1 month. Additionally, Resident #46 lost an additional 8 lbs from 1/9/2024 to 1/23/2024. Resident #46 ultimately lost a total of 22 lbs (13.25%) over 6 weeks from 12/9/2024 to 1/23/2024. Resident #46 was discharged on [DATE] to another long-term care nursing facility. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the ADL verification worksheet for Resident #46 dated 12/9/2023 through 1/23/2024, revealed of the 141 meals delivered, 121 meals had no documentation of the percentage of total meal consumption. (85. 81% of meal percentages were not documented). Review of the undated Weight Loss Documentation, revealed an unknown author documented, Resident #46 had a weight loss of 11.1% (18 pounds) for 30 days. There was an undated Weight Loss Documentation form with only Resident #46 ' s name, Resident ID, Room Number and Physician Name filled in. At the bottom of this form there was a preprinted statement stating Reviewed with Interdisciplinary Team: This undated form did not have any weight loss data documented and there was no evidence the facility held an Interdisciplinary Team Meeting to discuss Resident #46 ' s significant and severe weight loss, instituted or carried out any interventions after the first 14 lbs. or subsequent weight loss. During an interview on 10/17/2024 at 3:00 PM, FM ZZZZ stated Resident #46 had been losing weight and she had been told Resident #46 was not fed some nights because he was asleep. FM ZZZZ stated she had requested Resident #46 have double portions. When she was asked who she requested the double portion, she could not remember who she had asked. [TRUNCATED]

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 44724 Based on review of the facility assessment, review of employee time sheets, review of the nursing home licensure check list and interview the facility failed to have sufficient nursing staff to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with the facility assessment. Failure to assure the facility had sufficient nursing staff had the potential to affect all residents residing in the facility. The Census on entrance was 109. The findings include: 1.Review of the FACILITY ASSESSMENT with review date of 8/28/2024 revealed, The community staffing plan is based on our resident population and their needs of care and support. The objective is to ensure we have enough staff to meet the needs of the residents at any given time including nights, weekends, and emergencies .Determining minimum staffing requirements at the federal and state level. Current active Federal requirements are for nursing homes to have sufficient staff to meet the needs of residents, the services of a registered nurse [RN] for at least 8 consecutive hours a day, 7 days a week .Individual staff assignment .Staff assignments are based on the census levels, the acuity level of our residents, and any special care considerations. Individual staff assignments are reviewed for coordination and continuity of care for residents. Nursing staff is primarily assigned to care for the same residents Our community has made a good faith effort and approach to ensure we have sufficient staff to meet the needs of our residents at any given time .For direct care staff our community has made a good faith effort and approach to staff the same number of RN ' s, LPN ' s [Licensed Practical Nurse], and C.N.A. ' s [Certified Nursing Assistant] on the weekend as during the weekday . 2. Review of the employee time sheets revealed 81 different agency staff in the nursing department (RNs, LPNs, and CNAs) that worked at the facility from 4/2024 to 6/2024. Review of the employee time sheets for 5/19/2024 revealed a total of staffing hours of 202.42 with a facility census of 113. The Per Patient Day (PPD-refers to nursing hours allocated to each resident per day) was 1. 79. Review of the Nursing Home Licensure Checklist for the weekends of 5/11/2024 through 6/30/2024, revealed on 6/8/2024 a total of staffing hours of 204 with a facility census of 117. The PPD was 1.74. Review of the employee time sheets for 6/9/2024 revealed a total of staffing hours of 221.89 with a facility census of 111. The PPD was 1.99. Review of the employee time sheets for 6/15/2024 revealed a total of staffing hours of 219.7 with a facility census of 111. The PPD was 1.97. Review of the employee time sheets for 6/23/2024 revealed a total of staffing hours of 199.5 with a facility census of 111. The PPD was 1.79. (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility ' s Nursing Home Licensure Checklist for 6/15/2024 and 6/23/2024 revealed the facility did not have the required 8 hours of Registered Nurse (RN) coverage. Review of the facility ' s employee time sheets for 6/15/2024 and 6/23/2024 revealed no RN coverage for at least 8 hours of consecutive coverage. During a telephone interview on 9/24/2024 at 3:45 PM, Certified Nursing Assistant (CNA) NN stated, .we were often under staffed .there were times I had to take care of the 400 hall by myself about 18 residents .I know during that time [referring to 5/8/2024 incident) we had some nights we only had 1 nurse .I quit in May due to staffing issues .I knew it wasn ' t a place I wanted to be . During a telephone interview on 9/27/2024 at 2:46 PM, Ombudsman QQ stated, .we have had concerns for that building related to staffing at night .residents have complained about not getting changed and call lights not being answered . During an interview on 11/6/2024 at 1:00 PM, the Administrator was asked why the payroll based journal (PBJ) for Quarter 3 2024 (April 1 - June 30) reflected 1 star staff rating and excessively low weekend staffing. The Administrator stated, .probably staffing may have been short .agency staff about 80 % [percent] when I got here [June 4,2024] .I do the PBJ reporting now . During an interview on 11/6/2024 at 1:27 PM, CNA L stated, .I use to work at the facility on 7 AM to 7 PM shift .I would have 14 to 15 residents during the day .several residents in the building are a 2 person lift .you spend time looking for equipment and someone to come help you get residents up .you don ' t have time to chart .they [the facility] can ' t keep anybody because the patients are such a heavy load [referring to the number of residents per CNA and the residents which required total care] .they had a staffing person I think she worked like two weeks and quit . During an interview on 11/6/2024 at 1:46 PM, CNA MMMMMM, stated, .I used to pick up shifts at the facility. I worked 7 AM to 7 PM usually .I usually cared for 15 residents .sometimes you were scheduled to pick up on different halls .they called it working the split which was hard to keep up with the residents .I don ' t work there anymore . During an interview on 11/6/2024 at 3:00 PM, the Activities Director stated, .I have been helping with staffing just making sure the days are covered .we haven ' t had anyone steady in staffing since 12/2023 . The Activities Director was asked if she gives any input to the QAPI [Quality Assurance Performance Improvement] meetings related to staff for the facility, had she been trained on the PBJ, and how does she determine how much staff the facility needs. The Activities Director stated, .I don ' t go to the Quality Assurance Performance Improvement [QAPI] meetings .I started helping in April [2024] .I know I have to have an RN for 8 hours .I try to have 14-16 patient ratio per techs [CNAs] for day shift .I try to get it to that point .I can request agency staff through [Staffing Agency #1] .we have contracted nurses through our facility that are scheduled by the month . The Activities Director was asked if she knew the staff turn over rate for the facility. The Activities Director stated, .I hadn ' t paid much attention to it .now the CEO [Center Executive Officer] will sometimes ask how many open positions we have .right now we have two open positions for Unit Managers, 3 full time day shift charge nurse positions, on nights we have 2 full time nurse positions, CNAs 4 full time day shift positions . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/7/2024 at 8:45 AM, the Administrator stated, .We haven ' t really had anybody in the staffing roll. The staffing was low, and I know of days we didn ' t have an RN in the building. We will just have to take the staffing tag and move on .[Named Activities Director] has just been filling in as staffing, she doesn ' t really understand the PBJ and I am not sure if we even have a CEO in the staffing roll to call . During an interview on 11/7/2024 at 9:09 AM, Administrator #2 was asked about staffing during his time as the Administrator for the facility. Administrator #2 stated, .we had staffing concerns, bunch of agency staff . we had a staffing coordinator for a short time .I think the Regional Nurse Consultant was looking at the PBJ report .we had difficulty every day of the week with staffing .staffing was discussed daily .nursing was the ones that oversaw that .staffing was a patchwork of different managers [Named Assistant Director of Nursing - ADON] .I think the Infection Control person helped some .it was a Committee effort to do staffing .

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 44724 Based on facility assessment, nursing home licensure checklist, employee time sheets, and interview, the facility failed to ensure Registered Nurse (RN) coverage for 8 consecutive hours a day, 7 days a week for 2 days in June of 2024. The findings include: Review of the FACILITY ASSESSMENT with review date of 8/28/2024 revealed, The community staffing plan is based on our resident population and their needs of care and support .Current active Federal requirements are for nursing homes to have sufficient staff to meet the needs of residents, the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week . Review of the facility ' s Nursing Home Licensure Checklist for 6/15/2024 and 6/23/2024 revealed the facility did not have the required 8 hours of RN coverage. Review of the facility ' s employee time sheets for 6/15/2024 and 6/23/2024 revealed no RN coverage for at least 8 hours of consecutive coverage. During an interview on 11/7/2024 at 8:45 AM, the Administrator stated, .The staffing was low, and I know of days we didn ' t have an RN in the building. We will just have to take the staffing tag and move on .

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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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38441 Based on the Board of Examiners of Nursing Home Administrators (BENHA) review, list of Director of Nursing (DON) staff, job description review, facility policy review, Quality Assurance Performance Improvement (QAPI) Plan, Licensed Independent Practitioner Scope of Services, and interview, the facility Administration failed to administer the facility in a manner that enabled the facility to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of vulnerable residents in the facility. The facility Administration failed to provide oversight of clinical staff and follow-up on a resident with a recent long and severe history of illicit/street drug abuse. The facility Administration failed to provide oversight of staff to prevent all types of abuse of vulnerable and cognitively impaired residents in the facility, to intervene immediately in observed abuse, and to timely report allegations of abuse. The facility Administration's failures resulted in Immediate Jeopardy for Resident #4, #5, #2, #3, #35, and #19: Resident #4, who staff observed in Resident #5 s room on 7/7/2024, sitting on his bed with her face over his groin area. Staff did not immediately intervene and left the residents alone in the room. Resident #2 reported to staff on 5/8/2024 that Resident #3 sexually assaulted her by anal penetration. Resident #3 continued to wander the building throughout the night, and the allegation was not reported until the morning of 5/9/2024. Resident #35, when staff observed a family member strike the resident, failed to immediately intervene, and left the family member alone with the resident on 12/21/2023. Resident #19, who overdosed on cocaine in the facility, became unresponsive and was transferred to the hospital on 11/8/2023, after he reported to the Psychiatric Nurse Practitioner (NP) MM on 11/6/2023 that he had a history of weekly crack cocaine use and had not used for 3-4 weeks. The facility's Administration failed to thoroughly investigate each allegation of abuse and neglect. The facility's Administration failed to adequately monitor and ensure a plan to treat and prevent significant weight loss for 5 vulnerable residents (Resident #67, #65, #63, #45 and #46). Resident #67 experienced a significant and severe weight loss of approximately 9.0% over 2 months from 8/15/2024 to 10/14/2024. Resident #65 experienced a significant and severe weight loss of approximately 8.5% over 1 month from 8/9/2024 to 9/13/2024. Resident #63 experienced a significant and severe weight loss of approximately 10.19% over 3.5 months from 2/5/2024 to 5/20/2024. Resident #45 experienced a significant weight loss of approximately 5.0% over 1.6 months from 2/5/2024 to 3/25/2024. Resident #46 experienced a significant and severe weight loss of approximately 13.5% over 1.5 months from 12/9/2023 to 1/23/2024. The facility's Administration failed to identify the lack of monitoring meal consumption and staff aiding assisted diners with meals which contributed to continued decline in their nutritional status. The facility Administration's failures related to abuse and neglect and nutritional status resulted in Immediate Jeopardy. Immediate Jeopardy (IJ) is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator was notified of the Immediate jeopardy at F835 on 11/7/2024 at 7:22 PM, in the Conference Room. The facility was cited Immediate Jeopardy at F-835 at a scope and severity of L. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility was cited Immediate Jeopardy at F-600 at a scope and severity of L, which is substandard quality of care. The facility was cited F-609 and F-610 at a scope and severity of k, which is substandard quality of care. The facility was cited F-837 and F-867 at a scope and severity of L. The IJ began on 11/8/2023 and is ongoing. The facility is required to submit a plan of correction. The findings include: 1. Review of the BENHA revealed the facility had 3 Administrators in the past 12 months. Administrator #3 was employed by the facility from 9/5/2023 through 1/31/2024, Administrator #2 was employed by the facility from 2/1/2024 through 6/3/2024, and Administrator #1 was employed by the facility from 6/4/2024 through the present. 2. Review of a handwritten list of the Director of Nursing (DON) staff employed at the facility from July 2023 to the present and provided by the facility on 10/29/2024, revealed DON LL filled the DON role from July 2023 through April 2024, the Former Interim DON filled the DON role from April 2024 through July 2024, and the current DON filled the DON role from July 2024 to the present. 3. Review of the Administrator's Job Description with a revision date of 9/21/2020, revealed .The Administrator is responsible for establishing and directing the facility's overall day-to-day operations, both internal and external, and coordinate and maintain compliance to maximize high standards of care to patients .To perform this job, an individual must accomplish each essential function satisfactorily .Select and hire appropriate personnel to supervise activities of all departments .Determine staffing needs of the facility . Conduct in-service and supervisory training meetings .Meet with personnel as required and scheduled to assist in identifying and correcting issues, and/or the improvement of services .Ensure cognizance of appropriate admission, transfer and discharge patients .Direct various committees of the facility .quality assessment and assurance .Perform routine rounds .during all 24 hour shifts to ensure proper care of residents and staff is working efficiently .Assist in compliance efforts regarding state and/or federal requirements .Monitor procedures to ensure compliance with the state and federal guidelines, laws, regulations and company policies .successfully complete required training .Make decisions under pressure . COMPANY COMPETENCIES .Respect--We treat people as they want to be treated, showing regard for their rights .Professionalism--We perform our duties with skill, good judgement and politeness .Able to gather and analyze data and reach appropriate conclusion .Use logic and reasoning to identify changes in patients' conditions to determine the correct plan of action .Accepts responsibility for own decisions, actions and results .able to maintain dependable behavior in times of crisis or complexity .Upholds organizational values and abides by state and federal regulations .Maintains high level of performance while demonstrating commitment to accuracy and thoroughness .Communicates with co-workers at all levels to adequately meet the needs of patients . Review of the dated and signed Administrator's Job Descriptions from 9/6/2023 through the present revealed the following: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administrator #3 signed the Administrator's Job Description on 9/6/2023 Administrator #2 signed the Administrator's Job Description on 1/22/2024. The current Administrator signed the Administrator's Job Description on 5/29/2024. Review of the Director of Nursing Job Description with a revision date of 12/7/2020, revealed .The Director of Nursing is to manage the nursing department and administer the nursing programs in compliance with state and federal regulations as well as company policy and procedures .Plan, develop, organize, implement, evaluate, and direct the Nursing Services Department .in compliance with rules and regulations governing long term care facilities, employers and in accordance with facility policy. This included .Licensed staff . Nursing assistances .Physician's orders .Physician's visits .Medication reviews and administration audits . In-services/education .Upkeep of all QA [Quality Assurance] logs maintained in the DON public folder . Recognize and respond to changes in residents' conditions and document observations, interventions and outcomes .Arrange for and oversee the admission, transfer and discharge of residents .Participate in surveys made by authorized government agencies .Review, monitor, intervene, and document complaints and grievances from residents, families, visitors, and employees .Participate in various committees of the facility . care plans .pharmaceutical .quality assessment and assurance, compliance committee, QAPI [Quality Assurance and Performance Improvement] .Audit documentation for errors or inconsistencies and make necessary corrections, or document reasons for corrections not made .Handle multiple priorities effectively . Independent discretion/decision making .Make decisions under pressure .Upholds organizational values and abides by state and federal regulation .Demonstrates knowledge of the position and industry . 4. Review of the facility policy titled, Administration of Facility, with a revision date of 1/1/2023, and an effective date of 12/19/2023, revealed .This facility shall provide policies and systems to ensure that it is administered in a manner that shall focus on attaining and maintaining the highest practicable physical, mental, and psychosocial well-being of each resident Facility shall follow the accepted professional standards and principles of the various practice acts and regulations for the various licensed personnel within the facility. The facility shall employ professionals necessary to carry out the provisions of requirement .An appropriately licensed Administrator .shall be appointed by the governing body to be responsible for the management and overall operation of the facility .The facility must have a governing body that is legally responsible for the management and overall operation of the facility .This facility is obliged to meet provisions pertaining to nondiscrimination based on .abuse . 5. Review of the facility's QAPI Plan, reviewed 1/2024, revealed .Establish a facility-wide process to identify opportunities for improvement through continuous attention to quality of care, quality of life and Resident safety .Address gaps in systems or processes .Establish clear expectations around safety, quality, rights, choice, and respect .Continually improve the quality of care and services provided to our Residents .The Governing Body and the facility administration shall provide general oversight for Quality Assurance and Performance Improvement activities related to Resident care and services throughout the facility . 6. Review of the LICENSED INDEPENDENT PRACTITIONER SCOPE OF SERVICES, dated 7/17/2023, revealed Practitioner Name: [Named Nurse Practitioner (NP) MM] .Area of Privileging .Psychiatry/Psych [Psychiatric] NP/Psychology/Licensed Professional Counselor .Inclusions .Disease and mental health related conditions . The document was signed by NP MM on 7/17/2023 and by the Medical Director on 7/18/2023. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	7. On 7/7/2024, Certified Nursing Assistant (CNA) O entered Resident #5's room and saw Resident #4 with her face leaning over the groin area of Resident #5, who quickly pulled up his pants when the CNA entered the room. CNA O failed to immediately intervene, left the two residents alone, and failed to protect the residents from further sexual abuse. During an interview on 9/10/2024 at 10:31 AM, the Administrator stated he was the abuse coordinator. The Administrator was asked what he expected staff to do when they witness any type of abuse. The administrator replied he expected staff to separate the residents immediately, report the incident to a supervisor, and notify administration. The facility administration failed to maintain an effective QAPI process to follow up on abuse and failed to provide a safe environment for vulnerable residents who wandered in the facility. 8. On 5/8/2024, Resident #2 alleged Resident #3 walked into her room, naked from the waist down, climbed into her bed, and attempted to penetrate her anally, which caused psychosocial HARM for Resident #2 and Resident #7. During a telephone interview on 9/30/2024 at 2:30 PM, Administrator #2 stated, .Resident #2's story changed and in the end that didn t really happen . Administrator #2 was asked did the facility investigate as to why Resident #2 laid dirty without covers until the next morning. Administrator #2 stated, .I don't recall if it was investigated about why she laid in her feces During a telephone interview on 10/15/2024 at 12:30 PM, Administrator #2 stated, .I think the reason I did not substantiate it [5/8/2024 allegation of sexual abuse] because later [Resident #2] recanted her story .he [Resident #3] really didn t try to do that, I am saying the story changed .it was inconclusive about the penetration . Administrator #2 was asked would it take Resident #2 being penetrated to substantiate abuse. Administrator #2 stated, .I guess I don't know the answer to that .I'm not saying abuse did not occur .I was the Abuse Coordinator during that time . The facility administration failed to recognize sexual abuse, the ramifications for a vulnerable resident who experienced sexual abuse and failed to provide a safe environment for a vulnerable resident who had a known history to wander upon admission. 9. On 12/21/2023, 2 CNAs failed to prevent and intervene when Resident #35, a vulnerable resident with Intellectual Disability, was physically abused by Family Member (FM) FFFF which resulted in actual HARM when she sustained scratches on her chest and psychosocial HARM to the resident. During an interview on 10/17/2024 at 10:31 AM, Administrator #3 was asked if he was aware the 2 CNAs left the resident after they witnessed FM FFFF hit Resident #35. Administrator #3 stated, .no, one stayed with her [Resident #35] and the other let the nurse know .I am not sure what was documented in the chart . The facility administration failed to perform a thorough investigation for reported physical abuse which resulted in physical harm for Resident #35. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During a telephone interview on 10/14/2024 at 12:31 PM, Administrator 3 was asked to tell this surveyor about the morning meetings and stated, Our department heads, DON, ADON [Assistant DON], infection control .dietary, all your dept heads, occasionally the Medical Director would pop in, occasionally some regional staff .discuss the prior days, review the 24 hour report from the day before, go over reportables .kind of discuss what we were doing to address these things, any kind of education that was given to the staff . Administrator #3 was asked were the 24-hour report sheets kept. Administrator #3 stated, I know that's what we do at a lot of buildings, at that particular point in time I don't know where the DON was keeping them . should be a binder. Administrator #3 was asked who covered for the ADON when she was in the hospital in October and November of 2023. Administrator #3 stated, .honestly it would have been delegated throughout the building, MDS took on some of her things, the DON took on some of her things, Risk Manager took on some of those things . Administrator #3 was asked what was the process for the Psych NP's (NP MM) notes to be sent to and received by the facility. Administrator #3 stated, .the Psych NP [NP MM] would see [the residents], and from what I understand, they fax over all their notes and then we're responsible for scanning those into the proper place. When asked if those notes came to the ADON, Administrator #3 stated, I'm not one hundred percent certain who they were addressed to. Administrator #3 was asked did he know what the was turnaround time (for NP MM's notes) was after she evaluated a resident. Administrator #3 stated, . usually pretty quick. When asked what the process was when she (NP MM) identified concerns with a resident, Administrator #3 stated, .when there's [there are] issues identified, orders changed, we're going to make those changes .act as quickly as we can .just as soon as possible. Administrator #3 was asked if he was aware that Resident #19 reported to NP MM on 11/6/2023, 2 days before he overdosed on 11/8/2023, that he had an extensive history of weekly cocaine use. Administrator #3 stated, I do not recall that particular detail no .you have to understand at that particular location it's fairly common to get a lot of referrals that have a history of drug use, but nothing stood out differently . When asked should the facility have been notified (of Resident #19's recent history of crack cocaine abuse) Administrator #3 stated, I think it depends on the situation, of course you want to be notified of those things, but if it's under control and he's not drug seeking .he relapsed and that was unfortunate, but our response would be to take care of him .of course we want to be notified as soon as possible .honestly this is the first time I've had to deal with an overdose . Administrator #3 was asked would he expect the Psych NP (NP MM) to notify either he or the DON of a history of weekly drug abuse, and that information not just be put in her (NP MM's) notes. Administrator #3 stated, I really can't answer that question as far as should she notify us .I guess so potentially. Administrator #3 was asked considering what happened with Resident #19, should he or the DON have been notified (of Resident #19's history). Administrator #3 stated, Of course. Looking back is hindsight .always going to be what could we have done differently. During an interview on 10/14/2024 at 12:38 PM, the DON stated, I couldn't find any [morning meeting documentation notes for October and November 2023] .found [20]18, [20]19, and [20]20, but not [20]23. The facility Administration failed to maintain oversight to implement policies and procedures to prevent resident abuse and neglect in the facility. Refer to F-600. The facility Administration failed to ensure all allegations of abuse and neglect were reported to all required agencies timely. (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

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Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Refer to F-609 The facility Administration failed to ensure all allegations of abuse and neglect were investigated thoroughly and completely and failed to identify a root cause of each allegation and/or incident of abuse and neglect investigated. Refer to F-610 The facility Administration failed to address a systemic failure to prevent significant to severe weight loss and failed to provide the proper assistance and documentation needed to properly assess nutritional needs. Refer to F-692 The facility Administration failed to provide ongoing communication between the facility Administrative Staff and the Governing Body to ensure identified concerns were addressed in a timely manner. The Governing Body failed to provide oversight over the QAPI Program to ensure an effective QAPI plan was established and implemented to address, timely report, and thoroughly investigate allegations of sexual abuse, physical abuse, and neglect. Refer to F-837 The facility Administration failed to provide oversight, establish, and implement policies and procedures to ensure an effective QAPI program was maintained in the facility.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. 38441 Based on facility policy review, Quality Assurance Performance Improvement (QAPI) meeting minutes review, and interview, the facility ' s Governing Body consisting of the present Administrator, Senior [NAME] President of Operations, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Assistant Director of Nursing, and the Director of Nursing failed to provide oversight for the QAPI Program to ensure an effective QAPI plan was established and implemented to address, timely report, and thoroughly investigate allegations of sexual abuse, physical abuse, and neglect. The Governing Body failed to ensure the QAPI Program established and implemented effective interventions to address nutritional needs for vulnerable residents that resulted in significant weight loss. The failure of the facility ' s Governing Body resulted in Immediate Jeopardy (IJ), (a situation in which the provider ' s noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment or death to a resident.) The Administrator was notified of the immediate Jeopardy for F-837 on 11/7/2024 at 7:00 PM, in the Administrator ' s office. The facility was cited Immediate Jeopardy for F-837 with a scope and severity of L. The Immediate Jeopardy began on 11/8/2023 and is ongoing. A partial extended survey was conducted 9/19/2024 through 11/7/2024. The facility is required to submit a Plan of Correction (POC). The findings include: 1.Review of the facility policy titled, Governing Body, dated 1/2/2024, revealed .governing body .shall provide general oversight for the Quality Assurance and Performance Improvement activities, quality of care and safety related to resident care, treatment, and services throughout the facility .is legally responsible for the management and operation of the facility .is responsible and accountable for the QAPI program .Ensure the ongoing QAPI program is defined, implemented, and maintained .Ensure the QAPI efforts address priorities for improved quality of care and patient safety . 1. Review of the facility policy titled, QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN, dated January 2024, revealed .The Quality Assurance Performance Improvement (QAPI) Plan is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving the quality of life and services throughout the facility .The Governing Body and the facility administration shall provide general oversight for Quality Assurance and Performance Improvement activities related to Resident care and services throughout the facility . (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Review of the 2024 QAPI Program meeting minutes for June, July, and August failed to show interventions were established and implemented to address identified concerns related to resident abuse, neglect, and nutritional status decline that resulted in significant weight loss. The facility ' s Administration failed to provide an environment free from sexual, physical, verbal abuse, and deprivation of goods and services by staff for Residents #2, #3, #4, #5, #19, #35, and #49. Refer to F-600 The facility failed to timely report allegations of abuse and neglect for Residents #2, #3, and #19. Refer to F-609 The facility failed to conduct a thorough investigation and take appropriate corrective actions for Residents #2, #3, #4, #5, #7 and #19. Refer to F-610 The facility failed to monitor and address residents ' nutritional status and implement pertinent interventions that resulted in significant and/or severe weight loss for Residents #67, #65, #63, #45 and #46. Refer to F-692 3.During interview on 11/7/2024 at 5:10 PM the Administrator was asked to describe the governing body ' s role related to the facility ' s QAPI program. The Administrator stated, .The governing body is responsible for what the QAPI Committee does . The Administrator was unable to provide documentation to show the 2024 QAPI Committee established, implemented and monitored a QAPI plan to address identified concerns related to prevention, reporting, and investigating allegations of abuse and neglect, as well as nutritional status decline that resulted in significant weight loss. During a telephone interview on 11/7/2024 at 6:14 PM, the Regional Director of Operations (RDO) stated the governing body was responsible for oversight of the facility ' s QAPI program.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on policy review, job description review, Quality Assurance and Performance Improvement (QAPI) Minutes review, QAPI sign-in sheets, facility investigation, and interview, the QAPI Committee failed to ensure an effective QAPI program that systematically identified, reported, tracked, investigated, analyzed and used data and information related to all types of abuse and nutritional status in the facility. The QAPI committee failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently. Immediate Jeopardy (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) was identified in relation to the QAPI committee ' s failure ensure residents were free from abuse and neglect when staff observed Resident #4 sitting on Resident #5 ' s bed with her face over his exposed groin area, failed to intervene, and left the residents alone on 7/7/2024, when Resident #2 reported to staff on 5/8/2024 that she was sexually assaulted through anal penetration by Resident #3, who continued to wander the facility the remainder of the night, when staff observed a family member physically abuse Resident #35 on 12/21/2023, failed to intervene, and left the resident alone with the family member, and when Resident #19 reported an extensive weekly history of crack cocaine abuse to the Psychiatric Nurse Practitioner (NP MM) on 11/6/2023, no interventions were implemented, and Resident #19 overdosed on cocaine in the facility on 11/8/2023. The QAPI committee ' s failure to ensure appropriate interventions were implemented, to track and trend, and follow up on significant and severe weight loss resulted in Immediate Jeopardy when Resident #45 experienced significant weight loss, and when Resident #46, #63, #65, and #67 experienced severe weight loss. The Administrator was notified of the immediate Jeopardy for F-867 on 11/7/2024 at 7:00 PM, in the Administrator ' s office. The facility was cited Immediate Jeopardy at F-867 at a scope and severity of L. The facility was cited Immediate Jeopardy at F-600 at a scope and severity of L, which is substandard quality of care. The facility was cited Immediate Jeopardy at F-609, and F-610, and F-692 at a scope and severity of K, which is substandard quality of care. The facility was cited Immediate Jeopardy at F-835 and F-837 at a scope and severity of L. The Immediate Jeopardy began on 11/8/2023 and is ongoing. The facility is required to submit a plan of correction. The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1. Review of the facility policy titled, QUALITY ASSURANCE PERFORMANCE IMPROVEMENT PLAN, reviewed January 2024, revealed .The Quality Assurance Performance Improvement (QAPI) Plan is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving the quality of life and services throughout the facility .Objectives .include . Establish a facility-wide process to identify opportunities for improvement through continuous attention to quality of care, quality of life and Resident safety .Address gaps in systems or processes .Establish clear expectations around safety, quality, rights, choice, and respect. Continually improve the quality of care and services provided to our Residents .The facility will maintain documented evidence of the QAPI Program and will be able to demonstrate its operation .The QAPI Program focuses on systems and processes .The QAPI Program is used to guide decision making and day-to-day operations .facilitates decision making that is based on data .The facility sets goals for performance and measures progress toward those goals .The aim is safety and high quality with all clinical interventions .The QAPI Program utilizes the best available evidence (such as state and/or national benchmarks, published best practices, clinical guidelines) to determine appropriate care and define and measure goals .Performance Improvement activities encompass all organization-wide systems, processes, structures, outcomes, services, and key functions including, but not limited to .Administrative Services .Medical Staff .Nursing Services .The Governing body has assigned the responsibility to the Quality Assurance Performance Improvement Committee to set priorities for its performance improvement activities within the above listed services that .Focus on high-risk, high-volume, or problem-prone areas or systems .Consider incidence, prevalence, and severity of problems in those areas . The facility uses a systematic approach to determine when in-depth analysis is needed to fully understand a problem, its causes, and implications of change. The facility uses a thorough and highly organized/structed approach to determine the root cause of identified problems .will utilize a variety of tools to describe the current process used, and to identify any areas of breakdown or weakness in the current process. Systems are in place to monitor care and services drawing data from multiple sources .Performance indicators are used to monitor a wide range of care processes and outcomes, including tracking, investigating, and monitoring adverse events and investigation protocols to include action plans to prevent recurrences .The facility has established an organization-wide approach in designing, measuring, assessing, and improving the systems, processes and individual competencies required in performing organizational functions. The choice of methodology selected is the PDCA (Plan, Do, Check, Act) model .Design (Plan) .design stage is used to create a new process or improve or revise an existing process .Measure (Do) .During this phase, performance activities are analyzed to determine whether opportunities to improve performance exist . Assess (Check) During this phase, the data that has been collected will be interpreted .to determine the current level of performance and the stability of the current processes, identify opportunities for improvement in processes, and identify the need to redesign processes .Improve (Act) .After actions have been taken or recommendations implemented, data on the performance of those aspects of care, services, or functions that were to be improved are again monitored and evaluated to determine if the action was successful .The Governing Body and the facility administration shall provide general oversight for Quality Assurance and Performance Improvement activities related to Resident care and services throughout the facility . (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	2. Review of the Administrator Job Description with a revision date of 9/21/2020, revealed .The Administrator is responsible for establishing and directing the facility ' s overall day-to-day operations, both internal and external, and coordinate and maintain compliance to maximize high standards of care to patients .To perform this job, an individual must accomplish each essential function satisfactorily .Meet with personnel as required and scheduled to assist in identifying and correcting issues, and/or the improvement of services .Ensure cognizance of appropriate admission, transfer and discharge patients .Direct various committees of the facility .quality assessment and assurance .Assist in compliance efforts regarding state and/or federal requirements .Monitor procedures to ensure compliance with the state and federal guidelines, laws, regulations and company policies .Able to gather and analyze data and reach appropriate conclusion .Use logic and reasoning to identify changes in patients ' conditions to determine the correct plan of action . Accepts responsibility for own decisions, actions and results .Upholds organizational values and abides by state and federal regulations .Communicates with co-workers at all levels to adequately meet the needs of patients . Review of the Director of Nursing (DON) Job Description with a revision date of 12/7/2020, revealed .The Director of Nursing is to manage the nursing department and administer the nursing programs in compliance with state and federal regulations as well as company policy and procedures .Upkeep of all QA [Quality Assurance] logs maintained in the DON public folder .Participate in various committees of the facility; such as care plans .quality assessment and assurance, compliance committee, QAPI .and those assigned by the Administrator . 3. Review of the QAPI meeting minutes dated 8/27/2024, revealed the facility was unable to provide documentation that the allegation of sexual abuse involving Resident #4 and #5 on 7/7/2024 and Resident #2 and #3 on 5/8/2024 was discussed or followed up on in the August meeting. Review of the QAPI meeting minutes dated 7/23/2024, revealed .There were no adverse events in the month of May .There were no allegations of abuse and neglect in the month of May . The facility was unable to provide documentation that the allegation of sexual abuse involving Resident #4 and #5 on 7/7/2024 and Resident #2 and #3 on 5/8/2024 was discussed or followed up on in the July QAPI meeting. Review of the ADHOC QAPI Committee meeting minutes dated 7/8/2024 revealed, .DO: Intervention/Improvements .Staff Competency Demonstration: Post Test Question with education completion .Start Date 7/15/24 [2024] What do you hope to accomplish? Prevent reoccurrence of behaviors leading to potential or actual sexual interactions with resident who lack capacity to consent. What is the frequency of review? Weekly Review for 4 weeks, Monthly for 2 Months, then quarterly . The facility was unable to provide evidence that the interventions with the post tests, weekly reviews for 4 weeks or monthly for 2 months were completed. Review of the QAPI meeting minutes dated 6/13/2024, revealed the facility was unable to provide documentation that Resident #2 ' s allegation of sexual abuse by Resident #3 on 5/9/2024 was discussed or followed up on in the June QAPI meeting. During a telephone interview on 10/15/2024 at 9:34 AM, Administrator #2 was asked if a root cause analysis was performed after the allegation of sexual abuse on 5/8/2024. The Administrator stated, I don ' t know that we called it a root cause analysis. I am not at my office right now. I will review my notes and call you back. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 10/15/2024 at 11:09 AM, the DON stated, the Ad Hoc sheet is all I have, there is no documentation as to what was discussed for the 5/9/2024 Ad Hoc meeting. During a telephone interview on 10/15/2024 at 12:30 PM, Administrator #2 stated, .I don ' t have any documentation related to the Ad Hoc meeting for 5/9/2024 . The facility was unable to provide sign-in sheets or documentation that a QAPI meeting was conducted in January, February, March, April, or May of 2024. Review of the QAPI meeting minutes dated 12/27/2023, revealed the facility was unable to provide documentation that Resident #35 ' s physical abuse by a family member on 12/21/2023 was discussed or that follow up was conducted on Resident #19 ' s cocaine overdose in the facility on 11/8/2023, in the December QAPI meeting. Review of the QAPI meeting minutes dated 11/30/2023, revealed the facility was unable to provide documentation that Resident #19 ' s cocaine overdose in the facility on 11/8/2023 was discussed or followed up on in the November QAPI meeting. Review of the QAPI meeting minutes and sign-in sheets revealed the facility was unable to provide a sign-in sheet or QAPI minutes documenting an Ad Hoc QAPI committee was conducted on 11/8/2023 or 11/9/2023. During an interview on 10/14/2024 at 12:00 PM, the Medical Doctor stated, .it is tough to say whether the QAPI implementation for the month of May related to alleged sexual abuse could have prevented the second sexual abuse allegation for the month of July .there was wandering with both instances .[Resident #4] could not consent to sexual activity . During an interview on 10/18/2024 at 11:01 AM, Licensed Practical Nurse/Staff Educator BBB stated, .I don ' t go to the QAPI meetings. I have done in-service on abuse mainly going by the facility policy .the Administrator hasn ' t asked me to present something different .just asked me to do in-service on abuse . During an interview on 10/18/2024 at 9:30 AM, the Administrator stated they did an Ad Hoc meeting and the Governing Body met related to the alleged sexual incident with Resident #4 and Resident #5. Resident #4 was sent to the hospital and received a psych visit. We spoke to Resident #5 ' s family and he was discharged . When I started back on 6/6/2024, QAPI was 2 months behind. I only had 2 left in management staff and the Director of Nursing was an agency nurse. When I came here, we had to work on building a team. The Administrator was asked to present documentation related to daily morning meetings from 11/2023 to 5/2024 where the facility discussed and followed up on the abuse allegations. The Administrator was unable to find morning meetings documented from the date he left as Administrator on 6/15/2023 until 6/6/2024 when he started back at the facility. 7. On 12/21/2023, 2 Certified Nursing Assistants (CNAs) failed to prevent and intervene when Resident #35, a vulnerable resident with Intellectual Disability, was physically abused by Family Member (FM) FFFF which resulted in an injury. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	8. Resident #19 admitted to the facility on [DATE] and the Psychiatric Nurse Practitioner (NP MM) evaluated him on 11/6/2023. NP MM documented in her notes that Resident #19 reported an extensive history of crack cocaine use on a weekly basis and that he seemed to minimize the history. NP MM failed to verbally communicate verbally Resident #19 ' s history of cocaine abuse to facility staff, however, documented the history in her notes which were electronically signed on 11/7/2023. NP MM and the facility failed to recommend interventions for Resident #19 and the QAPI Committee failed to identify NP MM ' s documentation of Resident #10 ' s illicit drug abuse history as part of their investigation. During a telephone interview 10/14/2023 at 12:31 PM, Administrator #3 stated an Ad Hoc QAPI meeting was conducted after Resident #19 overdosed. Administrator #3 was asked did he recall when the Ad Hoc QAPI meeting was conducted following Resident #19 ' s overdose on 11/8/2023. Administrator #3 stated, It would have been the following morning .I remember us discussing that he was sent out. Administrator #3 was asked where that meeting was documented, did all of the attendees sign-in, and were the (QAPI) minutes retained. Administrator #3 stated, It would have been on one of those morning meeting sheets we keep .the Ad Hoc QAPI would have been part of that . Administrator #3 was asked should that documentation be a part of the facility ' s investigation. Administrator #3 stated, It should have been copied and put into the investigation so that would have been on me. Administrator #3 was asked should QAPI minutes and sign-in sheets be kept. Administrator #3 stated, Yeah .we have tons of them but sometimes they may get moved around. Administrator #3 was asked how often the facility conducted QAPI meetings. Administrator #3 stated, Monthly, daily morning meeting, then monthly . During a telephone interview on 10/15/2024 at 9:09 AM, Licensed Practical Nurse (LPN) DDD acknowledged that she was the facility ' s Risk Manager in October and November of 2023. LPN DDD was asked did she attend QAPI meetings. LPN DD stated, When we had them. LPN DDD stated, Honestly, I remember having one [QAPI Meeting] with that Administrator [Administrator #3]. I turned in my QAPI every month, but I can ' t say we went over much. LPN DDD stated the facility did not conduct monthly QAPI meetings during the time period Administrator #3 was employed as the Administrator. LPN DDD stated, No ma ' am, we did not, prior to him coming we did. LPN DDD was asked did she recall if (Resident #19 ' s) cocaine overdose was discussed in a QAPI meeting. LPN DDD stated, I recall it being discussed in morning meeting but not in a QAPI meeting .we discussed it minimally. LPN DDD stated she would not consider the morning meeting a QAPI meeting. LPN DD was asked did she recall if the QAPI Committee conducted a Root Cause Analysis into Resident #19 ' s overdose. LPN DDD stated, No, ma ' am. During an interview on 10/15/2024 at 10:06 AM, the MDS Coordinator acknowledged that she attended monthly QAPI meetings. The MDS Coordinator was asked were the QAPI meetings held monthly when Administrator #3 worked at the facility. The MDS Coordinator stated, I ' m not gonna [going to] say they were because I ' m not sure. The MDS Coordinator was asked to tell this surveyor about the QAPI meeting where Resident #19 ' s overdose was discussed and did they have an Ad Hoc QAPI meeting after the incident. The MDS Coordinator stated, I don ' t think we did [have an Ad Hoc QAPI meeting]. I know we did discuss it in the morning meeting. The MDS Coordinator could not recall if the facility conducted a Root Cause Analysis into the resident ' s overdose. The MDS Coordinator was asked did the QAPI Committee discuss NP MM ' s notes that identified he (Resident #19) had an extensive history of weekly crack cocaine abuse. The MDS Coordinator stated, I don ' t think so. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	During an interview on 10/15/2024 at 11:11 AM, the DON reviewed the facility ' s investigation into Resident #19 ' s overdose and acknowledged the incident should have been reported to the State Survey Agency within 2 hours, was not submitted until 11/9/2023, and was not submitted to the state agency timely. The DON was asked to look through the investigation and see where the QAPI Committe conducted a root cause analysis on Resident #19 ' s overdose in the facility. The DON stated, I don ' t see it. The DON was asked should that be included in the investigation and stated, Yes. During an interview on 10/15/2024 12:29 PM, Administrator #3 was asked did the QAPI Committee conduct a Root Cause Analysis on Resident #19 ' s overdose in the facility on 11/8/2023. Administrator #3 stated, We determined that there ' s really nothing we could have done to prevent it . Administrator #3 was asked what was determined to be the root cause Resident #19 ' s overdose occurred. Administrator #3 stated, .at the end of day there was nothing we could have done. Administrator #3 acknowledged that the facility used a Root Cause Analysis Form for the incident but could not locate the form. Administrator #3 was given the investigation provided by the facility and asked if the documentation of the Root Cause Analysis and Ad Hoc QAPI meeting was present. Administrator #3 stated, It would have been on that morning meeting sheet .It ' s not in the stack . Administrator #3 was asked could he show this surveyor where Resident #19 ' s overdose was discussed in QAPI. Administrator #3 stated, I cannot find the piece of paper that it ' s on .been 2 Administrators [since he was Administrator]. Administrator #3 was asked how long the facility should keep QAPI information and stated, .years, I think maybe it ' s 10 .I agree it should be available to you. Administrator #3 was asked if the facility identified an adverse or significant event should that be carried through their QAPI notes. Administrator #3 stated, We should have .I don ' t see it there. 9. Review of the medical record revealed Resident #45, a severely cognitively impaired resident, was admitted to the facility on [DATE]. Resident #45 had 2 hospitalization s related to dehydration and experienced a significant weight loss of approximately 5% from 2/5/2024 to 3/25/2024. Resident #58, the roommate of Resident #45, reported staff does not offer Resident #45 fluids and had even not fed her until the night shift arrived. Resident #45 had 76.87% of meal percentages that were not documented. The QAPI committee failed to recognize a systemic failure and did not identify the status of nutrition. 10. Review of the medical record revealed Resident #46 was admitted to the facility on [DATE] and discharged on [DATE]. Resident #46 had a 22 lb (13.25%) over 6 weeks from 12/9/2024 to 1/23/2024 and there was 85.81% of meal percentages not documented. The QAPI committee failed to identify and monitor a systemic failure that led to significant to severe weight loss. 11. Review of the medical record revealed Resident #63, a moderately cognitively impaired resident, was admitted to the facility on [DATE] and experienced a significant to severe weight loss from 2/5/2024 through 5/20/2024 of approximately 10.19% or 16 lbs over 3.5 months. 79.05% of meal percentages were not documented. The QAPI committee failed to identify and monitor nutritional status of residents from a systemic failure. 12. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE]. Resident #65, a moderately cognitively impaired resident, experienced a significant to severe weight loss of approximately 8.5% over 1 month from 8/9/2024 to 8/19/2024. Observations were made with Resident #65 not being assisted at meals or offered a substitute and eating less than 10% of meals. CNA GGGGGG and other CNAs failed to document meal percentages due to no access to the kiosk. The QAPI committee failed to identify the systemic breakdown related to nutrition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	12. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE]. Resident #67, a severely impaired cognitive resident experienced a significant to severe weight loss from 8/15/2024 through 10/14/2024 for a loss of approximately 9.0%. On 8/15/2024, Resident #67 weighed 142.0 lbs [pounds] and was down to 129.2 lbs by 10/14/2024, approximately 2 months later. Inconsistent documentation led to 56.11% of meal percentages were not documented. The RD reported that she depends heavily on accurate staff documentation for her recommendations. The QAPI committee failed identify a system failure related to nutrition and led to significant to severe weight loss. During an interview on 11/7/2024 at 5:25 PM, the Administrator stated the QAPI committee consisted of the Administrator, DON, ADON, MDS Coordinator, Social Services, Environmental Supervisor, Activities Coordinator, Staffing, Risk (if the facility has one), and the MD. When asked how often the QAPI team meets, the Administrator stated, .We are required to meet quarterly .we do it monthly .we are two months behind at this time . The Administrator was asked how QAPI dealt with weight loss in the facility. He stated, . We are doing weekly weights to try to determine the root cause of the weight loss .we work with the Regional Dietician .she comes by monthly and gives us a report .she goes through everybody ' s diet and tells us who flagged for weight loss . The Administrator was then asked if he was aware that documentation for meal percentages were not being done and he stated, .I was made aware of this issue when the State started the investigation .It is being addressed now .There was a Governing Body call today discussing it .we are looking through with the RD and the Certified Dietary Manager (CDM) to come up with a plan to address all the significant weight losses .to ensure everyone is documenting meal percentages eaten and offering an alternative if they decline their meal . Continued interview revealed the Administrator was asked about agency staff not being able to access the system. He stated that they should, but he would find out. When asked what the expectations were for documentation of meal percentages, the Administrator stated he would expect 100% documentation on every meal. The Administrator was then asked how he could say residents who have significant weight loss were being fed with no documentation to support this. He stated, .I can ' t say they are .if it ' s not documented, it didn ' t happen . Further interview revealed the Administrator was asked the root cause of the weight loss. He stated, .We are working on that now .first we have to determine who has access and who does not have access . The Administrator was then asked if it was acceptable for staff to set up a tray for an assisted diner, leave the room, and not encourage a resident to try to eat. He stated, No. The QAPI Committee failed to prevent resident abuse and neglect in the facility and failed to monitor, follow up on, and track and trend allegations of abuse. Refer to F-600 The QAPI Committee failed to ensure facility staff reported all allegations of abuse and neglect to the appropriate agencies in a timely manner. Refer to F-609. The QAPI Committee failed to ensure facility staff thoroughly and completely investigated all allegations of abuse to develop a root cause and prevent reoccurrence of abuse in the facility. Refer to F-610. (continued on next page)

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	445262	A. Building B. Wing	11/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eaton Creek Post Acute	4343 Ashland City Highway Nashville, TN 37218

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The QAPI Committee failed to ensure facility staff prevented significant and severe weight loss to maintain nutritional status and failed to identify systemic failures that led to weight loss. Refer to F-692 The QAPI Committee failed to ensure the facility was administered in a manner that allowed it to use its resources effectively and efficiently to attain or maintain the residents highest practicable level of well-being. Refer to F-835. The facility ' s Governing Body consisting of the present Administrator, Senior [NAME] President of Operations, Regional Director of Operations, Assistant [NAME] President of Clinical Operations, Regional Nurse Manager, Assistant Director of Nursing, and the Director of Nursing failed to provide oversight for the QAPI Program to ensure an effective QAPI plan was established and implemented to address, timely report, and thoroughly investigate allegations of sexual abuse, physical abuse, and neglect. The Governing Body failed to ensure the QAPI Program established and implemented effective interventions to address nutritional needs for vulnerable residents that resulted in significant weight loss. Refer to F-837.