

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/05/2024
NAME OF PROVIDER OR SUPPLIER Green Hills Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 Hillsboro Circle Nashville, TN 37215	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724</p> <p>Based on facility policy review, facility video footage, hospital record review, www.accuweather.com review, medical record review, observation, and interview, the facility failed to provide an environment that remained free of accident hazards and failed to adequately supervise Resident #106. Resident #106 exited the building in his wheelchair when a staff member unlocked the front door for a visitor to exit. Resident #106 followed the visitor out the door unnoticed on 12/8/2023 at 12:31 PM. Resident #106 exited the building for a second time when a staff member again unlocked the front door for a visitor and Resident #106 followed the visitor out the door unnoticed on 12/8/2023 at approximately 1:35 PM. The facility was unaware of Resident #106 missing until approximately 9:00 PM on 12/8/2023 (7 1/2 hours after Resident #106 exited the front door). The facility was unable to find Resident #106. The facility failed to investigate and determine the root-cause and no new interventions were put into place immediately following the first incident. The facility failed to prevent Resident #106 from moving unsupervised from a safe environment to an unsafe environment on 12/8/2023 on two separate occasions. The facility's failure to provide adequate supervision 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).</p> <p>The Director of Nursing (DON) in the Administrator's office and the Administrator via telephone were notified of the Immediate Jeopardy on 12/20/2023 at 6:27 PM. The DON was given the IJ Template. The DON and the Administrator were given the opportunity to ask questions.</p> <p>The facility was cited Immediate Jeopardy at F-689 at the scope and severity of J, which is Substandard Quality of Care.</p> <p>The F689 Immediate Jeopardy began on 12/8/2023 through 12/28/2023. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on 12/28/2024 at 4:09 PM. The corrective actions were validated onsite by the surveyors on 12/29/2023.</p> <p>The facility's noncompliance at F689 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions.</p> <p>The facility must submit a Plan of Correction.</p> <p>The findings include:</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy titled Accidents Incidents Investigating, dated 5/19/2023 revealed, .All accidents or incidents involving residents .occurring on our premises shall be investigated and reported to the administrator .1.The nurse supervisor/charge nurse and/or the department director or supervisor shall promptly initiate and document investigation for the accident or incident .k. Any corrective action taken .7. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities .</p> <p>Review of the facility policy titled, Wandering and Elopements, dated 5/19/2023 revealed, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. 1. If identifies as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. 2. If an employee observes a resident leaving the premises, he/she should: a. attempt to prevent the resident from leaving in a courteous manner .b. get help from other staff members .c. instruct another staff member to inform the charge nurse or director of nursing services that a resident is attempting to leave or has left the premises .3. If a resident is missing, initiate the elopement/missing resident emergency procedure: b. If the resident was not authorized to leave, initiate a search of the building (s) and premises .</p> <p>Review of the (facility) video footage dated 12/8/2023 revealed Resident #106 exited out the front door behind a visitor on 12/8/2023 at 12:31 PM, wearing his blue jean jacket and a beanie hat on with his Bible in his hand. He was seated in a wheelchair with his cane hanging to the right side of his wheelchair. Resident #106 rolled out to the entrance area, locked his wheelchair and transferred himself to the outside bench to the right of the exit door. The Former Interim Director of Nursing (IDON) #2 was standing in the lobby area when Resident #106 left behind a visitor. The Former IDON #2 looked out the exit door, started to walk away but turned around and exited the front door at 12:32 PM to talk to Resident #106. The Former IDON #2 then came back in the facility at 12:33 PM, Resident #106, continued to sit outside and transferred himself back to his wheelchair. While the Former IDON #2 was outside with Resident #106, the Business Office Manager talked to the Administrator and pointed to the exit door. The Administrator then exited the front door at 12:33:31 PM, talked to Resident #106, and the resident allowed the Administrator to roll him back into the facility and the resident rolled his wheelchair toward the 100 hall. Resident #106 came back to the front lobby at 1:29 PM. The Front Desk Clerk pushed the remote to open the front door for a visitor at 1:34:58 PM and the visitor exited the front door at 1:34:59 PM. The Front Desk Clerk turned his back to the exit door and left the desk at 1:35:01 PM. The Front Desk Clerk did not stay to monitor or visualize the closure of the front exit door and Resident #106 left the facility again behind a visitor without staff knowledge on 12/8/2023 at 1:35:13 PM. The Front Desk Clerk came back to the front desk at 1:35:30 PM along with Maintenance staff #1. Continued review of the video footage revealed during Resident #106's travel down the sloped sidewalk toward the street, 38 cars traveled the busy 4 lane road during a time span of 1 minute and 22 seconds. Within 1 second of Resident #106 rolling in his wheelchair, dropping off from the sidewalk to a lower level directly in front of the road, a car traveled by in front of Resident #106.</p> <p>Review of www.accuweather.com, the temperature in Nashville on 12/8/2023 was a low of 30 degrees Fahrenheit and a high of 51 degrees Fahrenheit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Review of Hospital #4's History and Physical for Resident #106 dated 9/30/2023 revealed, .[Named Resident #106] is a 77 YO [Year Old] .male with a PMH [past medical history] of HTN [Hypertension], arthritis (s/p status post hip replacement), homelessness .hx (history) of MI [Myocardial Infarction] who presented to the ED [Emergency Department] after 'passing out' in the bathroom of a Nashville .bus station early this morning. Patient originally from [NAME], TN [Tennessee] but had to relocate due to a house fire last Friday, during which he sustained no major injuries. Patient proceeded to stay with friends from various cities, including Memphis, TN and [NAME], TN, where he stayed overnight in [Named Hospital #5] for observation because of the smoke inhalation injury. Following this stay, patient rode the .bus to Nashville. Upon getting off the bus station, he went to go use the bathroom, during which he described feeling 'very hot'and immediately slumped onto the bathroom stall. He is unsure of how long he was out, but he remembers the officers pulling him out of the bathroom and performing sternal rubs . Continued review of Hospital #4's Progress Note for Resident #106 dated 10/2/2023 revealed .Chief Complaint .Where am I going to go, I lost everything .His chief concern .is no longer having a place to live after being displaced by an apt [apartment] fire .overall interview was tangential [relating to or along a tangent, diverging from a previous course or line; erratic thoughts} with pt [patient] referring to political and religious beliefs when asked about symptoms .</p> <p>Review of the medical record revealed Resident #106 was admitted to the facility on [DATE] and exited the facility on 12/8/2023. Resident #106 was admitted with a diagnosis which included Syncope and Collapse, Essential Hypertension (HTN), Arthropathy, and Old Myocardial Infarction (MI).</p> <p>Review of Resident #106's Progress Notes revealed, .10/9/2023 .Physician Visit Note .Chief complaint weakness history of present illness the patient is a [AGE] year-old man with a history of hypertension arthritis hip replacement and homelessness who was admitted for further evaluation and treatment of weakness .He was thought to be dehydrated for the most part .was admitted to .hospital after being found unconscious in a bus station bathroom .</p> <p>Review of the 5-day scheduled Minimum Data Set (MDS) dated [DATE] revealed Resident #106's device used was a manual wheelchair, supervision required with walk 10 feet (ft) and walk 50 ft with two turns, walk 150 feet, walk 10 feet on uneven surfaces, and ability to go up and down a curb and/or up and down one step not attempted due to medical condition or safety concerns. Further review of the MDS revealed a fall in the last month.</p> <p>Review of Resident #106's Progress Notes revealed, .11/29/2023 .Nurse Practitioner Note .Patient seen for skilled follow up visit .He is asking to go outside, which is fine if he remains in courtyard area, requested that staff accompany him .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/19/2023 at 3:45 PM, the Administrator stated, .I found out after [Named Resident #106] left that he told employees that day he was going to leave . The Administrator was asked on 12/8/2023 when he was notified [Named Resident 106] was missing? The Administrator stated, .I will try to recall the timing, around 9:30 or 10:00 PM. [Named Resident #106] was mobile around the center. He would do Bible study on different floors .I think [RN #1] notified me. [Named Maintenance staff #1] was able to look at security camera and seen when he [Named Resident #106] went out the front door [Named Resident #106] loved to be outside and about 1 hour prior, he did leave the building and sat on outside bench. I told him he needed to come back in. I discourage residents sitting on the front because several cars drive through this area .We notified the police department .</p> <p>During an interview on 12/19/2023 at 4:00 PM, Maintenance staff #1 revealed the video footage for [Named Resident #106] exiting the front door. The Maintenance staff #1 stated, .the facility has a remote that opens the exit door .It was hard for the staff behind the desk to see the exit door .</p> <p>During an interview on 12/19/2023 at 7:12 PM, RN #1 stated, .I was rounding around 8:30 - 9:00 PM and a nurse, I can't remember her name, she was on the 1st floor asked me if I had seen [Named Resident #106]. Usually, he would be in the bed at that time. I went to his room; his things were still in his room and his supper tray had not been touched. He kept a box on his table with his clothes in it .I immediately started looking for him and went outside .SSD said he didn't get discharged , techs said he was saying he was going home that day. We didn't get that in a nurse report that he was saying he was going home. He [Resident #106] was not found. The Administrator and the police came out to the facility. The Administrator . did tell me he [Resident #106] was homeless .The facility doesn't like for residents to sit out front because it is not safe. He [Named Resident #106] used the back courtyard to go outside sometimes .the nurse was doing her night medications and that is how she realized he was not here at the facility .</p> <p>During an interview on 12/20/2023 at 9:05 AM, Certified Nursing Assistant (CNA) #32 stated, .I delivered [Named Resident #106] food tray at lunch on 12/8/2023. He wandered around to other floors. He would eat his food, take a nap and go back upstairs .He said he was going home weekly. He said at the nurse's desk that day 'I am going home today' .</p> <p>During an interview on 12/20/2023 at 9:20 AM, CNA #19 stated (Named Resident #106) kept his stuff packed up all the time.</p> <p>During an interview on 12/20/2023 at 9:25 AM, CNA #33 (who was sitting and works at the front desk) stated, .the facility does an orientation related to working the front exit door .showed us how to work the phones .how to open the door .the camera is here for the front door so I can see who is coming to the door so I can let them in . CNA #33 was asked if she received any training related to watching the door when someone exits the building or educated on monitoring of the closing of the exit door. CNA #33 stated, No, we were told residents were not allowed to sit out front without someone being with them.</p> <p>During an interview on 12/20/2023 at 9:35 AM, Maintenance #2 stated, .I got a call that someone was missing. We went into action. I looked around the area for 1 1/2 hours. I think it was 11:00 PM when I got a call. I know it was Saturday morning before I got back home around 3:00 AM .He [Resident #106] would say all the time he was going to leave .I found his wheelchair the next day. It was over in front of our fence .I don't think we have someone sitting at the desk all the time .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 12/20/2023 at 10:45 AM, the Administrator stated, "[Named Former IDON #2] asked me to go speak to [Named Resident #106] because he was sitting outside at the front entrance and the staff all know, I am concerned about residents being in that area because of delivery trucks coming through this area. I would rather the residents go to the courtyard. Saturday [12/9/2023] morning, facts started to come out that he was saying he was going to leave. The Administrator was asked why the AMA (discharge Against Medical Advice) form was dated with his signature on 12/9/2023 (the day after Resident #106 left the facility)? The Administrator stated, 'I completed that to state the reason he left. I did not talk to him about the risk of leaving AMA. The Administrator was asked if he reviewed the video footage? He stated, 'I did not review the video footage.'</p> <p>During an interview on 12/20/2023 at 11:33 AM, Respiratory Therapist #1 stated, 'I saw [Named Resident #106] a couple of times. He told me he was leaving and asked 'Is that my discharge paperwork to go back home to my work?' I didn't know he was going to go out. I didn't tell anyone about what [Named Resident #106] said.'</p> <p>During an interview on 12/20/2023 at 12:15 PM, Former IDON #2 stated, 'I remember [Named Resident #106]. I did go outside when I saw him sitting on the bench out front and I told him he couldn't sit out front that he could sit outside in the courtyard. Then I told the Administrator and I had to leave for the day. It was normal for him to want to go out, but we don't want residents out front because it's not safe. He talked about going home all the time.'</p> <p>During an interview on 12/20/2023 at 1:58 PM, the Director of Nursing [DON] and the Administrator revealed an investigation was not completed when [Named Resident #106] left the facility. The Administrator stated, 'I didn't blame the receptionist [Named Front Desk Clerk]. The Administrator was asked when an incident or accident occurs what should the facility do? The Administrator stated, '1st thing to be done. A root cause analysis is what we should do. The Administrator was asked when [Named Resident #106] exited the facility behind a visitor without a staff member what did the facility do? The Administrator stated, 'I didn't do anything about staff watching the exit door. I didn't consider an in-service related to the front door. I didn't see the exit door as being a problem. I don't think we did a Quality Assurance Performance Improvement [QAPI] meeting.'</p> <p>During a telephone interview on 12/20/2023 at 3:52 PM, Dispatcher #1 for Police Department #1 stated, 'I do see where they looked for [Named Resident #106]. No police report was completed.'</p> <p>During a telephone interview on 12/20/2023 at 4:27 PM, Anonymous Employee #1 was asked if she was familiar with [Named Resident #106]. The Anonymous Employee #1 stated, 'yes. I understood his home burned down about a month ago. The Anonymous Employee #1 stated, 'at 10:38 PM on 12/8/2023 a group chat for the facility went out [to facility staff members] through an app the facility uses. [Named RN #1] was reaching out to see if he had been discharged. Multiple [staff members] were in the text. [Named RN #1] had not seen him. His dinner tray in his room was untouched. He [Named Resident #106] was confused at times. Anonymous Employee #1 was asked to give examples of times [Named Resident #106] was confused. Anonymous Employee #1 stated, 'for example. He said if he could make it to the airport, he had security there to pick him up. He would not use a telephone, said people were getting hooked on phones and people were being tracked that way. Told me if I ever needed to reach him to dial W975. He had a house fire because he was intertwined with the Mob, so they burned his house down. He talked about conspiracy theory. I know the facility is trying to say he went AMA [Against Medical Advice] but that isn't true.'</p> <p>(continued on next page)</p>		

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