STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center for Rehabilitation and Healing	3939 Hillsboro Circle Nashville, TN 37215

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, observation, and interview, the facility failed to treat 1 (Resident #88) of 22 sampled residents reviewed for resident rights with respect, dignity, and care in a manner and in an environment that promotes maintenance and enhancement of her quality of life. The findings include: Review off the policy titled, Door Safety System, dated 2/2023 revealed, .It is the policy of this facility to provide guidelines on utilizing and maintaining an Electronic Detection System to promote the safety of residents At-Risk for elopement .1. Resident Evaluation A. Resident are evaluated for Risk of Elopement on admission, readmission, quarterly, and as needed. B. Residents identified At-Risk for Elopement will be further evaluated for appropriate interventions, which may include use of an individual WanderGuard Tag Device [bracelet a resident wears with the sensors that when an at-risk wanderer gets close to a monitored door it will sound to alert staff] .D. Resident Care Plan will be updated accordingly. E. Individual WanderGuard Tag devices, when placed on a resident, will be activated using the hand-held WanderGuard Blue Detector. F. Individual WanderGuard Tag devices will be checked daily by Nursing to ensure they are functioning appropriately . 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 identified 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 .get help from other staff members to inform the immediate vicinity . 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 . (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled, ResidentRights [Resident Rights], dated 5/19/2023 revealed, .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .be free from abuse, neglect .self-determination .exercise his or her rights as a resident of the facility .be supported by the facility in exercising his or her rights .be informed about his or her rights and responsibilities .voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal .have the facility respond to his or her grievances . Review of the medical record revealed Resident #88 was admitted to the facility on [DATE] with a diagnosis of Chronic Obstructive Pulmonary Disease, Cirrhosis of the Liver, and Depression. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #88 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Review of comprehensive care plan dated 12/20/2022 revealed Resident #88 was independent for all activities of daily living (ADL). Continue review of the comprehensive care plan revealed, .Resident prefers to plan own day .The resident has the potential for a mood d/o [disorder] related to: diagnosis of depression and placement in a Skilled Nursing Facility .Monitor/record/report to MD prn [as needed] .sadness, loss of pleasure and interest in activities . depression, anxiety, sad mood as per facility behavior monitoring protocols . Review of the Progress Notes for Resident #88 revealed, .12/30/2023 20:04 (8:04 PM) Nursing Progress Note .Wander guard placed on her Right ankle Review of Resident #88's Progress Notes from 12/3/2023 through 12/30/2023 revealed no documentation of wandering, confusion, delirium, or exit seeking behavior. Observation and interview on 1/3/2024 at 9:45 AM revealed, Resident #88 was in the bed with call light in reach. Resident #88 was asked how she was doing? Resident #88 stated, .I am not doing good today .I am mad .I feel like I am in a Jail . Resident #88 was asked why she felt this way? Resident #88 stated, .this ankle bracelet I can't even go off the hall .the nurse put the bracelet on me about a week ago . Resident #88 stated, I had gone downstairs to go outside to the courtyard. Resident #88 stated, .the staff came running, some gray headed woman and a tech seen me going that way and said you can't go outside .the next morning they put this bracelet on my leg . Resident 88 stated, .I like to go out to get some fresh air, I didn't get to go outside . Resident #88 stated, .I like to read or color outside .I pitched a fit and the nurse said you will probably get kicked out if you don't wear it .I haven't been outside since then . During an interview on 1/4/2024 at 8:45 AM, Resident #88 was asked if she had been able to go outside or to any group activities; Resident #88 responded, .No, I would like to see the blue sky. They are keeping me inside the building. I still have this bracelet, can't take it off and I feel like I am on house arrest. I use to go out to the courtyard on the 1st floor. I just want this thing off. I have told a couple of nurses .it is just to track me . they are trying to control me .I don't want to leave I just want to got outside . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation and interview on 1/4/2024 at 4:20 PM revealed Resident #88 was observed with wanderguard bracelet in place on right ankle. Resident #88 stated, .I still have the ankle bracelet. I guess I will have to talk to [Named Administrator] about this bracelet if I ever get to go outside. I will probably have to wear it all the time until I finally get out of here . During an interview on 1/4/2024 at 4:30 PM, Licensed Practical Nurse (LPN) #18 was asked why Resident #88 had a wanderguard placed on her ankle. LPN #18 stated, .I understood she had walked downstairs, and the facility was afraid of her eloping .she walked out the door, I am not sure which door .she had gotten on the elevator went to Bingo on the 3rd floor and left Bingo got back on elevator and went down to 1st floor . [Named Resident #88] has complained about having to wear the bracelet, I don't feel like she wanted to wear it . LPN #18 was asked if Resident #88 had told her how the bracelet made her feel. LPN #18 stated, .I think the word she used was a prisoner . During a telephone interview on 1/27/2024 at 7:09 AM, LPN #41 was asked why she placed a wanderguard bracelet on Resident #88 on 12/30/2023. LPN #41 stated, .[Named Registered Nurse RN #3] asked me to place the bracelet .[Named Resident #88] had gone outside to the courtyard .[Named Resident #88] was back in her room and accounted for when I placed the bracelet .the courtyard does have a fence around it She [Named Resident #88] had the code to the door to go out [Named RN #3] will be here in 10 minutes you can call back and she can tell you more about what happened . LPN #41 was asked if [Named Resident #88] could have exited the courtyard. LPN #41 stated, No, she walks with a walker and the courtyard has a fence. During a telephone interview on 1/27/2024 at 7:35 AM, RN #3 was asked to explain why a wanderguard bracelet was placed on Resident #88. RN #3 stated, .She was .going out back in the courtyard She wasn't exiting the building . RN #3 was asked when does the facility place a wanderguard on a resident. RN #3 stated, When a patient is trying to exit the building. RN #3 was asked if [Named Resident #88] was trying to exit the building? RN #3 stated, She would normally ask to go outside .I explained to her that she can't go out without us knowing . During an interview on 1/30/2024 at 10:20 AM, Resident #88 stated, .I have had the code to go outside to the courtyard because I like to go out and look at the water that runs in front of the gate .It was the next day when they put the bracelet on me. I was just going outside; I wasn't leaving the building . Resident #88 was asked if she felt being made to wear the bracelet was against her rights. Resident #88 stated, Yes. During an interview on 1/31/2024 at 12:30 PM, the Regional Nurse Consultant #1 (recently designated Director of Nursing) was asked when should a wanderguard bracelet be placed on a resident. The Regional Nurse Consultant #1 stated, .if a resident was wandering without purpose which could be harmful to themselves .talk to the resident to see if the wandering was purposeful .diagnoses of Dementia .they would be at risk of leaving the facility . The Regional Nurse Consultant #1 was asked to explain the resident access to the gated courtyard for the facility. The Regional Nurse Consultant #1 stated, .it has a gate around it the residents have been allowed to go out to the courtyard . The Regional Nurse Consultant #1 was asked why Resident #88 received a wanderguard on 12/30/2023. The Regional Nurse Consultant #1 stated, .I haven't talked to [Named Resident #88] . (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/31/2024 at 12:45 PM with Regional Nurse Consultant #1 present; Resident #88 was asked how the wanderguard bracelet made her feel. Resident #88 stated, .like I am in jail .I don't want to wear the bracelet .I told 2 nurses I didn't want to wear it .I was told if you're here you got to wear it. I just wanted to go outside and get some fresh air. I had the code to the door . During an interview in the courtyard on 1/31/2024 at 1:00 PM, the Maintenance staff #1 stated, .all the alert residents are given the code to the door to go out to the courtyard .there is a doorbell to ring when the resident wants to come back in from the courtyard .I haven't changed the code on the door in months because the residents should be able to go out when they want .

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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 - Actual harm Residents Affected - Few	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, review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, medical record review, facility investigation review, and interview, the facility failed to protect the resident's right to be free from neglect for 1 of 22 (Resident #319) sampled residents reviewed for abuse. The facility's failure to provide the necessary structure and processes to meet the care needs of Resident #319 resulted in actual HARM when Resident #319 fell from the bed and sustained a left hip fracture. Staff failed to provide 2-person assistance during incontinent care, for a cognitively impaired resident with contractures (a permanent tightening of muscle, tendons, skin, and surrounding tissue that causes the joints to shorten and stiffen) and hemiparesis (paralysis and partial weakness of one side of the body). Staff failed to ensure Resident #319 was monitored for adverse outcomes related to the witnessed fall. Resident #319 remained in the facility with a major injury for 1 day before receiving treatment. On [DATE], Resident #319 was sent out to the Emergency Department (ED) for evaluation of neurological symptoms and the facility failed to report information related to the fall that occurred on [DATE] to the receiving facility and ensure safe transition of care. The facility also failed to ensure 2 of 22 (Resident #56 and Resident #81) residents reviewed for abuse were free from verbal abuse when Certified Nursing Assistant (CNA) #11 made verbal threats and derogatory statements to them on [DATE]. The failure of the facility to prevent resident abuse resulted in psychosocial HARM for Resident #56 and Resident #81. The findings include: Review of the facility's policy titled, .Fall Management, revised ,d+[DATE] revealed, .The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident's fall risk. A care plan is developed and implemented, based on this evaluation, with ongoing review .Care Plan updated as appropriate .Fall Event . When a fall occurs, the resident is assessed for injuries by the nurse .Complete an Incident/Accident Report . Complete .Progress Note .Add the fall event to 24-Hour Report .Initiate the Interdisciplinary Post-Fall Review .communicates resident falls to the attending physician .will discuss recommended interventions to reduce the potential for falls for the resident .IDT reviews all falls within ,d+[DATE] hours .IDT designee will discuss recommended significant changes .care plan will be reviewed and/or revised as indicated . Review of the policy titled, MDS [MDS Assessment] revised ,d+[DATE] revealed, .The Purpose of the Assessment .Is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity, as well as medical, cognitive, and emotional needs .The information derived from the MDS assessment is then used to assist the staff to care plan for the resident, so the resident may achieve/maintain their highest level of daily function . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date ,d+[DATE], revealed, .Residents have the right to be free from abuse, neglect .Protect residents from abuse, neglect .by anyone including, but not necessarily limited to .facility staff .staff from other agencies .Develop and implement policies and protocols to prevent and identify .abuse or mistreatment of residents .neglect of residents .Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems .Provide staff orientation and training/orientation programs that include topics such as abuse prevention, identification and reporting or abuse, stress management, and handling verbally or physically aggressive resident behavior .Identify and investigate all possible incidents of abuse, mistreatment .Investigate and report any allegations within timeframes required by federal requirements .Protect residents from any further harm during investigations . Review of the CMS RAI Version 3.0 Manual dated ,d+[DATE] revealed, . Section G0110: Activities of Daily Living Assistance dated ,d+[DATE] revealed, .How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting . Review of the medical record revealed Resident #319 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Other Sequelae of Cerebral Infarction (late effects of stroke), Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Speech and Language Deficits following Cerebrovascular Disease and Seizures. Review of the care plan for Resident #319 revealed, XXX[DATE] .at risk for falls r/t [related/to] stroke XXX[DATE] .on an platelet inhibitor XXX[DATE] .communicate best with yes/no questions post-stroke XXX[DATE] .chronic pain r/t Chronic Physical Disability XXX[DATE] .contractures XXX[DATE] .require assist with activities of daily living XXX[DATE] air mattress monitor placement and function XXX[DATE] Patient to wear LLE [Lower Left Extremity] knee extension [device to allow extension of lower extremity] daily as tolerated XXX[DATE] .Bed Mobility .Total Assist x [times] 2 Staff XXX[DATE] .Toilet Use .Total Dependence x 1 Staff XXX[DATE] Transfers .Totally Dependent x 2 Staff (Mechanical Lift) XXX[DATE] Remove air mattress . Continued review revealed there was no focus or interventions for Seizure diagnosis and no focus or interventions for risks associated with behaviors of jerking motions or spasms during care.There were no safety interventions for the air mattress included in the care plan. Review of Resident #319's Order Summary revealed, XXX[DATE] .Air Mattress-Monitor QShift [every shift] for Placement and Function XXX[DATE] .levETIRActam [anticonvulsant medication] Tablet 500 MG [milligram] two times a day for seizures . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Quarterly MDS assessment dated [DATE] revealed Resident #319 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Resident #319 required extensive assistance with two persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture and hygiene), total dependence with two persons physical assist for transfer (how resident moves between surfaces including to or from the bed, chair, wheelchair, or standing position (excludes to/from bath/toilet), total dependence with one-person physical assist for toilet use (how resident uses the toilet room, commode, bedpan, or urinal; transfers on/off toilet; cleanses self after elimination; changes pad; manages ostomy or catheter; and adjusts clothes) and required extensive assistance with two person physical assist for personal hygiene (how resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (excludes baths and showers). Continued review revealed Resident #319 was always incontinent of bowel and bladder. Resident #319 had active diagnoses which included Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke, Hemiplegia or Hemiparesis, Seizure Disorder or Epilepsy, Muscle Weakness, and Other Lack of Coordination. Resident #319 had a pressure reducing device to the bed. Review of the facility document (event/incident report) titled, Fall: Witnessed, dated [DATE] at 10:18 AM, revealed, .Incident Description: Resident was lying on side receiving patient care per CNA .to remove fecal matter .Resident grunted and moved his body like he was in pain and forcefully projected himself off of bed. Lower body was tense and appeared to be spasming .Level of Pain .5 .Mental Status .Lack of Safety Awareness .Predisposing Physiological Factors .Cognitive Impairment .Extremity Weakness-Upper . Communication Deficit .Extremity Weakness-Lower .Incontinent .Predisposing Situation Factors .History of Falls .Side Rails Up .No Witnesses found . Resident 319's fall was witnessed by the roommate and CNA#6. Review of the nursing progress notes for Resident #319 dated [DATE] through [DATE], revealed no documentation of monitoring/assessment for changes related to Resident #319's witnessed fall on [DATE] at 10:18 AM. Review of the facility eINTERACT [facility documentation tool] Transfer Form , dated [DATE] at 4:47 PM, revealed Resident #319 was sent to Hospital #2 for numbness on left side of head. Resident Representative and Medical Director (MD) were notified. Director of Nursing [Former DON #1] completed the transfer form and Licensed Practical Nurse [LPN] #36 called report to Hospital #2 at 4:34 PM. There was no documentation related to Resident #319's fall on [DATE] on the transfer form. Review of Hospital #2's Emergency Department [ED]records for Resident #319 dated [DATE] revealed, . CHIEF COMPLAINT .came by ems [Emergency Medical Service] from snf [Skilled Nursing Facility] #1 for numbness on the top of his head for 3 days .possible stroke .HISTORY OF PRESENT ILLNESS .He states that yesterday, he was pushed off of his bed by a CNA. He hurt his left hip, low back, and hit his head . XR[Xray] Hip 2 or 3 Views Left with Pelvis .IMPRESSION: Comminuted [bone broken into more than two pieces] fracture LEFT femoral neck extending to the lesser trochanter [left hip fracture] .Impressions the patient has a left femoral neck fracture from his fall . Review of the employee record for CNA #6 revealed no documented training for Activities of Daily Living (ADL) Care (DON #1 stated CNA #6 received training on ADLs with return demonstration). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility investigation statement dated [DATE], revealed, .Interview with [Resident #319]: Admin [Administration] and Social Services Director (SSD) #1 asked [Resident #319] to recall the incident he had spoken to [Named Family Member FM #14] about .[Resident #319] was asked to show how this incident occurred .SSD #1 turned her back to [Resident #319] and he placed both of his hands in a cupping motion underneath SSD #1's armpits and made a pushing motion away from [Resident #319]'s body . Review of the facility investigation statement dated [DATE], revealed, .Interview with [Resident #47] dated [DATE] .Admin and Social Services spoke to [Resident #47] concerning the incident. [Resident #47] said that he had witnessed his roommate fall to the floor with the staff member. He relayed that no pushing happened and that the lady [CNA#6] was changing him and he fell . Review of facility investigation statement dated [DATE] revealed, .[CNA #6] was asked by Admin and Social Services to recall the incident from yesterday [[DATE]]. She stated that she was performing patient care to [Named Resident #319]. She said that [Resident #319] was lying horizontal on his side on the bed when she was attempting to wipe [Resident #319]. She stated that [Resident #319] had jumped a little bit, enough to cause [Resident #319]'s legs to swing out of the bed. Review of the progress notes for Resident #319 dated [DATE] at 4:47 PM revealed, Registered Nurse (RN) #6 documented, .pt [patient] sent out due to family request. pt c/o [complained of] numbness on left side of head . During an interview on [DATE] at 3:35 PM, the Former DON #1 stated she went to Resident #319's room and completed a head-to-toe assessment when notified about the fall on [DATE]. (During interview with LPN #4 and CNA #6, they both denied the Former DON #1 was present in the room after Resident #319's fall.) The Former DON #1 stated, .When I entered the room, [Resident #319] was in a sitting position or maybe propped up against something .[Resident #319] rated his pain 5 of 10 to his left knee .[Resident #319] told me to just put him back in bed . The Former DON was asked if Resident #319 was provided an intervention for pain rated 5 of 10. The Former DON #1 replied, .[Resident #319] refused pain medication for pain in his knee and just wanted to be put back in bed . the Former DON #1 stated CNA #6 and LPN #4 were in the room and used a mechanical lift to place Resident #319 back in the bed. (During interview, LPN #4 and CNA #6 denied the use of a mechanical lift.) The Former DON #1 stated CNA #6 was performing incontinence care when Resident #319 slid off the bed. The Former DON was asked which way CNA #6 had Resident #319 turned for incontinence. The Former DON #1 replied, [Resident #319] was turned away from [CNA #6] and when [Resident #319] started to fall, I guess [CNA #6] came around to catch him. The Former DON #1 stated the CNAs are able to look at the Kardex for information involving residents' care plans. DON #1 was asked if nursing documented Resident 319's continuing assessment for changes post fall in the progress notes for Resident #319. She responded No, I am not sure what the policy is for follow up charting. During an interview on [DATE] at 10:17 AM, CNA #16 stated Resident #319 was incontinent and required a 2 person assist with a lift for transfers. CNA #16 stated, [Resident #319] would push back against you when he was rolled over and that's why I always used 2 people for his care, because it was safer. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:00 PM, the Rehab Director was asked what was included in assessment for bed mobility. He responded bed mobility included side to side, and sit to supine. The Rehab Director stated when a patient/resident is coded for 2-person assist for bed mobility, it would require a 2-person assist for incontinence care provided in bed. During a telephone interview on [DATE] at 9:05 AM, LPN #4 stated she was Resident #319's nurse on [DATE]. LPN #4 stated, .I was notified by [CNA #6] that [Resident #319] had fallen off the bed .the tech [CNA #6] stated [Resident #319] was turned on his side .His body tensed up and he threw his body onto the floor . This is not the first time he had the jerking movements during care .[Resident #319] said I don't know why I do this .LPN #4 stated, When I walked in the room, he was lying on the floor .It took several of us to get him up . LPN #4 was asked if she assessed Resident #319 on the floor. She responded, He had on a gown. I did not see any deformities. I tried to do what I could of a head-to-toe assessment while he was on the floor. When asked if a lift was used to put Resident #319 back in bed, LPN #4 replied, No. Three of us picked him up and placed him back in bed. LPN #4 stated DON #1 did not come to the room after the fall and complete an assessment. LPN #4 was asked ; have you received training to provide care of a patient on an air mattress. LPN #4 replied, No. LPN #4 was asked did Resident #319 require seizure precautions. LPN#4 responded, I don't think so. LPN #4 was asked if Resident #319 was care planned for jerking movements . LPN #4 replied, Yes, keep bed in lowest position. No interventions in place for jerking behaviors on current care plan. LPN #4 stated CNA #6 should have requested help when [Resident #319] clinched up (became stiff). LPN #4 was asked if there had been 2 CNAs providing incontinence care for Resident #319, would that have prevented the fall . LPN #4 replied, Yes. During a telephone interview on [DATE] at 11:02 AM, CNA #6 stated, .I was giving patient care and [Resident #319] was turned away from me .He jumped when I was cleaning his bottom .He has jumped before related to pain . CNA #6 stated, .I reached back to get some cream with one hand and kept the other hand on [Resident #319] and that's when he fell .[Resident #319] stiffened up and threw his legs off the bed . I jumped across the bed and grabbed him under his arms .[Resident #319] had jerking movements during care, that wasn't unusual. CNA #6 was asked if another CNA [2-person assist] had been present while performing incontinence care on Resident #319, would that have prevented Resident #319 from falling . CNA #6 replied, Yes, two people could have stopped him from falling .His care plan said 1 person assist . CNA #6 was asked if she was one of the 3 people that picked Resident #319 up from the floor ? CNA #6 responded, Yes, we did pick him up and he was groaning from pain. Further interview revealed CNA#6 received no training on ADL care of residents on an air mattress at SNF #1. During an interview on [DATE] at 11:16 AM, FM #14 stated, .[Resident #319] is paralyzed on the left side. FM #14 was asked if she had Resident #319 sent out to the hospital for symptoms of a stroke . FM #14 responded, .No, when I walked in that room, he started crying .He was in so much pain .I asked them then, are y'all going to send him out for Xray .The nurse said he doesn't have any broken bones .That's when I demanded [Resident #319] to be sent to the emergency room [ER] .He had not had another stroke; he had a broken hip .I talked to his roommate [Resident #47], he was in his right mind .[Named Resident #47] said [Resident #319] hit the floor .[SNF #1] said he never hit the floor . During a telephone interview on [DATE] at 4:15 PM, the SSD #1 stated, .During an interview on [DATE], I asked [Named Resident #319] to demonstrate how the CNA lowered him to the floor .I backed up to the bed and [Resident #319] extended his arms and reached under my arms like he was catching me . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center for Rehabilitation and Healing	3939 Hillsboro Circle Nashville, TN 37215

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:45 PM, the Former DON #1 stated the Interdisciplinary Team (IDT) investigated Resident #319's fall on [DATE] and determined the air mattress on his bed had contributed to him sliding off the bed due to him moving around and an air mattress being slick. The Former DON #1 stated residents on an air mattress should have a care plan with interventions in place. When asked what type of interventions would need to be implemented, Former DON #1 replied, .check placement and functioning, and do not use fitted sheets . When asked what is meant by placement and functioning of an air mattress, Former DON #1 replied, Placement is making sure the resident actually has the air mattress, the resident could have moved rooms and the mattress did not follow .Functioning means is the air mattress turned on, is it inflated. When asked if sheets should be used on an air mattress, the Former DON #1 replied, No, fitted sheets would prevent the mattress from properly inflating and could possibly turn off the CPR [Cardiopulmonary Resuscitation] function [This allows for a proper hard surface needed in which to initiate chest compressions and intubation]. The Former DON #1 stated she could not think of any safety interventions that would need to be implemented for use of an air mattress. Continued interview revealed the Former DON #1 stated she was not aware of Resident #319 having a diagnosis for seizures. The Former DON #1 stated she would expect his care plan to reflect a diagnosis for seizures with interventions implemented. DON #1 was unable to provide documentation related to a root cause analysis and investigation related to Resident #319's [DATE] fall. The Former DON #1 reviewed the transfer form dated [DATE] for Resident #319 and stated.The fall was not documented on the transfer form because [Resident #319] was not sent out for symptoms related to the fall . When asked if the information related to the fall on [DATE] was relevant information due to Resident #319 being transferred to the ER for symptoms of numbness of the scalp. The Former DON #1 replied, No. During an interview on [DATE] at 10:40 AM, the MDS Coordinator was asked to review Resident #319's quarterly assessment dated [DATE]. The MDS Coordinator was asked how she determined Resident #319 required extensive assistance of 2 persons for bed mobility, total dependence for toileting one person assist, and extensive assist of 2 persons for personal hygiene. The MDS Coordinator stated, .I would review the staffing documentation and make visual observations. If I code a resident as total assistance, then the CNA documentation must say the resident required total assistance all the time during the 7 day look back period . The MDS Coordinator was asked how Resident #319 could require 2 person assist for personal hygiene and only require 1 person assist for toileting. The MDS Coordinator stated, .I am not the CNA that cared for him so I can't tell you that . The MDS Coordinator was asked if the CNA documentation was always correct. The MDS Coordinator stated, No. During an interview on [DATE] at 2:50 PM, The MDS Coordinator was asked if seizures were checked on Resident #319's Care Area Assessment (CAA) and Resident #319 was on seizure medication twice a day, should Resident #319 have been care planned for seizures. The MDS Coordinator responded, .Seizures should have been care planned since he was on seizure medication . The MDS Coordinator was then asked if a resident was on an air mattress, should safety measures be care planned. The MDS Coordinator stated, . I don't usually put safety measures in for an air mattress . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 3:34 PM, LPN #36 stated he was the Unit Manager for 3rd floor on [DATE]. LPN #36 was unable to recall sending Resident #319 to theER on [DATE] and stated, .I always assisted the nurse during a transfer by calling report to the receiving facility .I used the Interact transfer form as a guide when calling report, and sent a copy of the form with the resident to the ER . The surveyor asked LPN #36 if information related to a fall the previous day would be included in the report to the receiving facility . LPN #36 replied, Yes. LPN #36 stated if he had known about Resident #319's fall on [DATE], he would have included it on the transfer form and in the call for report. LPN #36 stated if the information about the fall was not noted on the transfer form for Resident #319, then he was unaware of the fall. During an interview on [DATE] at 12:13 PM, Nurse Practitioner (NP) #3 stated she had no record that she or any other of the NP's at the facility had assessed Resident #319 after the fall on [DATE] . The facility failed to provide 2 person assistance during incontinence care that resulted Resident 319's fall with hip fracture. The facility failed to perform a thorough assessment after the fall, that led to Resident 319's delay of treatment until the following day. The facility failed to notify the receiving facility of Resident 319's fall with injury. _____ Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia, Osteomyelitis, and Type 2 Diabetes Mellitus. Review of the comprehensive care plan dated [DATE] Resident #56 revealed, .Focus Resident requires assist with activities of daily living .Interventions/Tasks .Roll left and right .Substantial/maximal assistance X 1 staff .Shower/Bathe self .Substantial/maximal assistance x 1 staff .Toileting hygiene .Substantial/maximal assistance required x 1 staff .Focus Mood/Behavior: I'm at risk of a change in my mood and behavior due to my diagnosis of MDD [Major Depressive Disorder] and anxiety disorder .Goal My behavior will not cause distress to myself and others .Interventions/Tasks .Encourage me to voice my feelings, fears, and concerns . Observe me for changes in my mood that may put me at risk for behaviors to occur .Provide me supportive listening and communication . Review of the Psychological Diagnostic Interview for Resident #56 dated [DATE] revealed, .[Named Resident #56] is being seen today for follow-up regarding any emotional needs since he reportedly observed verbal abuse of his roommate from a CNA, who is no longer in the facility .He was able to describe the events that occurred recently . Review of the Quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #56 was dependent for toileting, personal hygiene, and bathing which required extensive assistance of one person. Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included Encounter for Orthopedic Aftercare following surgical amputation, Type 2 Diabetes Mellitus, and Congestive Heart Failure (CHF). (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Psychological Diagnostic Interview for Resident #81 dated [DATE] revealed, .[Resident #81] related events related to the abuse, saying that he didn't sleep the night of the event, saying he was fearful for his safety . Review of the comprehensive care plan dated [DATE] Resident #81 revealed, .Focus Abuse/Neglect: I'm at risk for actual/potential abuse/neglect related to my dependence on others for ADL care .Goal I will not experience any form of abuse or neglect through review date .Interventions/Tasks Provide assistance with ADL's as needed .Provide support and ensure resident is free from abuse and/or neglect . Review of the Quarterly MDS assessment dated [DATE] revealed Resident #81 had a BIMS score of 15, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #81 was dependent for toileting, supervision related to personal hygiene, and substantial/maximum assistance with rolling left and right, sit to lying, and lying to sitting on side of bed. Review of the facility investigation dated [DATE] revealed, .Date/Time/Name of when staff became aware of this incident XXX[DATE] at 2:15 PM .Date/Time administrator was notified of the incident XXX[DATE] 2:35 PM .Date and time when the alleged incident occurred [DATE] 11:00 PM .[Named Resident #81] (BIM Brief Interview for Mental Status - 15) reported to the Unit Manager that he had a confrontation with his night shift [7:00 PM-7:00 AM [DATE]] CNA. Resident reported that the confrontation had arisen during a periodic check around midnight by the alleged perpetrator. Resident stated that he was upset with the frequency in which the same [CNA] had made rounds to check on him. Resident stated that the CNA was very argumentative and made a threatening remark when exiting the room. Resident has displayed no signs of psychosocial distress or harm .Residents roommate [Named Resident #56 BIM-15] corroborated [Named Resident #81 BIM - 15] allegation against CNA when questioned by administration .Administrator conducted a phone interview with the alleged perpetrator, [Named CNA #11], on [DATE] regarding the alleged incident. [Named CNA #11] stated that she mistakenly had thought that the Resident was independent with ADLs. [Named CNA #11] stated that when she checked on [Named Resident #81] around midnight he became very upset. [Named CNA #11] states [Named Resident #81] started cursing her out so she exited the room. [Named CNA #11] denied making any threatening statement to the Resident during the interaction . Continued review of the facility investigation revealed a written statement completed by Unit Manager [LPN #19] which stated, . Tech [CNA #11] came @ [at] 11[11:00 PM] - told them they were independent, told [Named Resident #81] she was brand new, he told her she still had to check them. She said 'you don't tell me what to do' 'I'll kick your ass, slamed [slammed] the bathroom door he sadi [said] '[expletive] you try it' She said '[expletive] you mother [expletive]', you can suck my ass' after confrontation She never came back 12 pm-7 am .She called [Resident #56] a'mfer' [expletive] . Review of the facility investigation revealed the allegation of abuse occurred on [DATE] around 11:00 PM - 12:00 AM [midnight] and was not reported to the Administrator until [DATE] at 2:35 PM. Review of CNA #11's employee clock in and clock out for [DATE] revealed the employee clocked in at 7:04 PM on [DATE] and clocked out at 7:03 AM on [DATE]. The allegation of abuse reported by Resident #81 revealed the interaction with the employee occurred around 11:00 PM - 12:00 AM on [DATE]. The employee clock in and clock out revealed CNA #11 worked the remainder of the shift past the time of the allegation of the verbal abuse. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Police Department #1's Incident Report dated [DATE] revealed, Dispatched .Report Date [DATE] . Victim [Named Resident #81] .Victim to Suspect Number 1 [Named CNA #11] .Complainant .[Named Administrator] .Narrative .[Named SNF #1] administrator .reported the following incident at the facility. [Resident #81] stated that on [DATE] at approximately 11:00pm [PM] he got into an argument with employee [CNA #11] employed at the facility. During the argument [Named CNA #11] allegedly said to [Named Resident #81] 'I'll kick your ass' . During an interview on [DATE] at 11:34 AM , Former DON #1 and Administrator confirmed they were notified of the allegation of verbal abuse on [DATE]. The Former DON #1 stated, .The written statement in the investigation was the Unit Manager's [LPN #19] statement of what [Named Resident #81] reported . The Administrator was asked if Resident #81's roommate (Resident #56) or any other employees that worked that shift were interviewed . The Administrator replied, If I had interviewed the roommate, it would be in the investigation. I didn't ask anyone else because they were not in ear shot, I would have thought the roommate would have been interviewed. I think the roommate was interviewed by the SSD. When I called [Named CNA #11] she had an attitude with me. I just had what [Named Resident #81] reported and it was conflicted with what [Named CNA #11] said happened. I was not aware [Named Resident #81] said he didn't sleep the night of the event and was fearful for his safety. The supervisor [LPN #26] for [DATE] denied knowing anything about it . During an interview on [DATE] at 12:20 PM, Resident #81 stated, . [Named CNA #11] threatened us, slammed the door, [Named CNA #2] another tech took care of me and my roommate the rest of the night. [Named CNA #11] never came in our room to check on us until 11:00 PM that night [[DATE]]. When [named CNA #11] came in the room I said 'are you not supposed to check on us every 2 hours.' The CNA told me to shut up and threatened to kick my ass. I did tell her [expletive] you and then [Named CNA #11] said suck my ass, no one wants to take care of you, she slammed the door so hard the clock almost fell off the wall. I told the supervisor that night, I can't remember the supervisor's name, but the [CNA #11] wasn't sent home. I saw [CNA #11] in the hallway about 12:00 AM and 1:00 AM . The night nurse was an agency nurse, she knew about what happened. I stayed up all night because I was scared, and my roommate was scared. I never seen anybody get that angry, they should have sent her home. I am pretty sure she worked all night. The supervisor on night shift didn't do anything. [Named CNA #11] called my roommate a mother [expletive] . During an interview on [DATE] at 12:55 PM, Resident #56 (Resident #81's roommate) stated, .[CNA #11] came in here about 11:00 PM [[DATE]], my roommate asked her why she was just now checking on us. [CNA #11] said she thought we could take care of ourselves. [CNA #11] was standing in the bathroom, yelling, woke me up, the CNA told my roommate to suck her ass and slammed the door. Resident #56 stated, .I didn't trust the girl, I was afraid she would hurt us .I s [TRUNCATED]

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, facility investigation review, medical record review, and interview, the facility failed to report to the state agency allegations of verbal abuse and neglect within 2 hours of the incident for 3 (Resident #53, Resident #56, and Resident #81) of 22 sampled residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, revealed, .Residents have the right to be free from abuse, neglect .This includes .verbal, mental .Protect residents from abuse, neglect .by anyone including, but not necessarily limited to .facility staff .staff from other agencies .implement policies and protocols to prevent and identify . abuse or mistreatment of residents .neglect of residents .Provide staff orientation and training/orientation programs that include topics .identification and reporting of abuse .Identify and investigate all possible incidents of abuse, mistreatment .Investigate and report any allegations within timeframes required by federal requirements .Protect residents from any further harm during investigations . Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses which included Peripheral Vascular Disease, Flaccid Hemiplegia Affecting Unspecified Side, Type 2 Diabetes Mellitus, and Epilepsy. Review of Resident #53's Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Resident #53 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #53 required substantial/maximal assistance with shower/bathe and setup of clean-up assistance with personal hygiene. Review of the comprehensive care plan dated 5/17/2022 revealed, .Focus .Resident requires assist with activities of daily living [ADL] .Interventions/Tasks .Assist with bed mobility, transfers, and bathing as required .Personal hygiene .Set up or clean up assistance required .Shower/bathe .Substantial/maximal assistance x 1 staff .Tub/Shower transfer .Dependent x 1 staff .Focus .The resident is at risk for actual/potential abuse/neglect r/t [related to] dependence on others for ADL care . Review of the facility investigation revealed, (Named Family Member [FM] #26) reported by telephone to nursing staff on 11/28/2022 at 6:00 PM felt (Named Resident #53) was being neglected. Continued review of the facility reported investigation revealed (FM #26) alleged she overheard verbal abuse over (Named Resident #53)'s cell phone. The neglect/verbal abuse was not reported to the State Agency (SA) until 11/29/2022 at 12:02 PM (18 hours and 2 minutes later). During an interview on 12/13/2023, Resident #53 was asked about her care at the facility. Resident #53 stated, .my family did complain about my showers not getting done and the CNA was very rude that evening . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia, Osteomyelitis, Type 2 Diabetes Mellitus and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15 which indicated no cognitive impairment. During an interview on 12/19/2023 at 12:55 PM, Resident #56 stated, .[Named CNA #11] came in here about 11:00 PM (9/14/2023), my roommate asked her why she was just now checking on us .the [Named CNA #11] was standing in the bathroom, yelling, woke me up, the CNA told my roommate to suck her ass and slammed the door. Resident #56 stated, .I didn't trust the girl, I was afraid she would hurt us .I stayed up all night . The CNA never came back in our room, but my roommate seen her in the hall later that night. Resident #56 further stated, she called me a mother [expletive], I don't know why .we stayed up that night because we were afraid she would come back in here . Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included Aftercare following surgical amputation, Type 2 Diabetes Mellitus, and Congestive Heart Failure. Review of the Quarterly MDS dated [DATE] revealed Resident #81 had a BIMS score of 15 which indicated no cognitive impairment. Review of the facility reported investigation dated 9/15/2023 revealed, .administrator was notified of the incident .09/15/2023 2:35 PM .Date and time when the alleged incident occurred 09/14/2023 11:00 PM . [Named Resident #81] (BIM Brief Interview for Mental Status - 15) reported to the Unit Manager that he had confrontation with his night shift [7 PM-7AM 9/14/2024] CNA. Review of the facility investigation revealed the allegation of abuse occurred on 9/14/2023 around 11:00 PM - 12:00 AM and was not reported to the Administrator until 9/15/2023 at 2:35 PM. The verbal abuse was not reported to the SA until 9/15/2023 at 2:41 PM (15 hours and 21 minutes later). During an interview on 12/19/2023 at 11:34 AM, the Former DON #1 and Administrator confirmed they were notified of the allegation of verbal abuse on 9/15/2023. The Administrator was asked if [Named Resident #56, Named Resident #81's roommate] or any other employees that worked that shift were interviewed.The supervisor [LPN #26] for 9/14/2023 denied knowing anything about it . During an interview on 12/19/2023 at 12:20 PM, Resident #81 stated, .[Named CNA #11] never came in our room to check on us until 11:00 PM that night [9/14/2023] .I told the supervisor that night .the night nurse was an agency nurse, she knew about what happened . During an interview on 12/19/2023 at 2:17 PM, SSD reviewed LPN #19's written statement. (the written statement was included in the facility investigation) SSD stated, .[Named Resident #81 and Named Resident #56] pretty much said the same thing. The CNA was mean and used derogatory language and told [Named Resident #81] I'll kick your ass .I do feel this was verbal abuse .the Administrator usually notifies me about potential abuse so I can interview the residents .[Named Resident #56] confirmed what happened .I would have told the Administrator .I don't know why the nurse didn't report it that night .Resident interviews are usually what I take care of in an investigation . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/19/2023 at 8:27 PM, LPN #21 stated, .I worked 9/14/2023 .I do remember that Caucasian resident [Named Resident #81] asked to speak to the nurse .I was trying to defuse the situation .I know the CNA was changed out and placed on another assignment .I don't remember the roommate saying anything .I told the nursing supervisor .I don't remember her name .and it was passed on to the day shift nurse .I don't remember the CNA that took care of the residents after this happened .the Administrator never asked me about it, you are the 1st person that has called me . During an interview on 1/4/2024 at 9:00 AM, (Named Resident #81) was asked when the incident occurred on 9/14/2023 how did it make him feel? (Named Resident #81) stated, .it made me angry; it made me sad because she said nobody wants to take care of me, I was dirty .needed to be changed .I told [Named CNA #27] about it .I felt apprehensive [anxious or fearful that something bad or unpleasant will happen] .scared she [CNA #11] would hit me in my sleep .we [Resident #81 and Resident #56] talked to supervisor and nurse .the supervisor asked me if I wanted the CNA back in here .I told her no .I told them exactly what she said to me .and my roommate heard it because she woke him up . During a telephone interview on 1/8/2024 at 12:10 PM, LPN #26 was asked if she was the supervisor on 9/14/2023. LPN #26 confirmed she was the supervisor. This surveyor read the statement from the facility's investigation, .Supervisor [LPN #26] in facility at time of alleged incident, had no knowledge of [Named CNA #11] cussing at resident . LPN #26 was asked if that was an accurate statement. LPN #26 stated, .absolutely not .I was notified by the tech [CNA #27] that night .I called him [Named Administrator] from my personal phone that night [9/14/2023] but he didn't answer. I told [Named CNA #27] to take care of [Resident #81 and Resident #56] the rest of the night .the next day the Administrator called me on a 3-way call, I am not sure who was on the call but there were other people besides the Administrator . During an interview on 1/10/2024 at 4:25 PM, Former DON #1 was asked when should an allegation of resident abuse be reported. The Former DON #1 stated within 2 hours. The Former DON #1 confirmed the allegation of resident abuse was not reported until the next day.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 thoroughly investigate an allegation of verbal abuse and/or neglect for 3 (Resident #53, Resident #56 and Resident #81) of 22 sampled residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, revealed, .Residents have the right to be free from abuse, neglect .verbal . Identify and investigate all possible incidents of abuse, mistreatment .Investigate and report any allegations within timeframes required by federal requirements .Protect residents from any further harm during investigations . The facility investigation revealed on 11/29/2022 at 10:56 AM the Former Director of Nursing (DON) #1 completed an interview with (Named FM #26). (Named FM #26) reported that she visited with (Named Resident #53) and the resident told her that she hadn't gotten a shower since 11/18/2022 and that the resident was being neglected. (Named FM #26) stated she spoke to nursing staff and nursing staff promised her that (Named Resident #53) would have her shower by the end of the shift. (Named Resident #53) called (Named FM #26) that evening and stated she still had not received a shower. The (Named FM #26) then called the facility at 6:00 pm spoke to a nurse who reported the shower would be offered again. (Named FM #26) then called (Named Resident #53) and waited on the telephone until the CNA came in to offer the shower. (Named FM #26) stated the CNA (Named CNA #8) came in and very rudely offered the resident a shower but was rushing her. It was noted in the facility investigation that Resident (Named Resident #53) has history of refusals and care planned for this. (There was no documentation in Resident #53's medical record of refusal of care and no focus on the care plan related to the refusal of care) Interviews completed with all residents on the unit with Brief Interview for Mental Status (BIMS) greater than 10, revealed no concerns for physical or verbal harm. The results of the facility investigation were .not verified due to evidence and history of shower refusals and from statements collected by nursing staff . Review of the medical record revealed Resident #53 was admitted to the facility on [DATE] with diagnoses which included Peripheral Vascular Disease, Flaccid Hemiplegia Affecting Unspecified Side, Type 2 Diabetes Mellitus, and Epilepsy. Review of the comprehensive care plan dated 5/17/2022 revealed, .Focus .Resident requires assist with activities of daily living .Interventions/Tasks .Assist with .bathing as required .Shower/bathe . Substantial/maximal assistance x 1 staff . The care plan had no focus or interventions addressing a history for refusal of care for showers/baths for the first 6 months of admission until 11/29/2022 Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed, Resident #53 had a BIMS score of 15, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #53 required substantial/maximal assistance with shower/bathe (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/13/2023, Resident #53 was asked about her care at the facility. Resident #53 stated, .my family did complain about my showers not getting done and the CNA was very rude that evening [11/29/2022] . The Former DON #1 was asked during her investigation did she question other residents to see if they had any concerns related to their showers. The Former DON #1 stated, .No I didn't ask the other residents . The Former DON #1 was asked did she investigate the reasons why [Named Resident #53] refused her showers. The Former DON #1 stated, .I did not try to investigate why the resident was refusing her showers . The Former DON #1 confirmed [Named Resident #53] had a history of refusing showers. The Former DON #1 was asked to review the care plan regarding (Named Resident #53) refusing care. The Former DON #1 reviewed the care plan including resolved and cancelled entries and was unable to find a focus or interventions for refusals of care. Review of the facility investigation dated 9/15/2023 revealed, .[Named Resident #81] (BIM Brief Interview for Mental Status - 15) reported to the Unit Manager that he had a confrontation with his night shift [7 PM-7AM 9/14/2024] CNA [Certified Nursing Assistant]. Resident reported that the confrontation had arisen during a periodic check around midnight by the alleged perpetrator. Resident stated that he was upset with the frequency in which the same {CNA} had made rounds to check on him. Resident stated that the CNA was very argumentative and made a threatening remark when exiting the room. Resident has displayed no signs of psychosocial distress or harm .Residents roommate [Named Resident #56 BIM-15] corroborated [Named Resident #81 BIM - 15] allegation against CNA when questioned by administration .Administrator conducted a phone interview with the alleged perpetrator, [Named CNA #11], on 9/15/2023 regarding the alleged incident. [Named CNA #11] stated that she mistakenly had thought that the Resident was independent with ADLs. [Named CNA #11] stated that when she checked on [Named Resident #81] around midnight he became very upset. [Named CNA #11] states [Named Resident #81] started cursing her out so she exited the room. [Named CNA #11] denied making any threatening statement to the Resident during the interaction . Allegation could not be verified based on conflicting statements received from the caregiver and Resident . Continued review of the facility investigation Facility investigation dated 9/15/2023 revealed a written statement completed by Unit Manager LPN #19 which stated, .Tech [CNA #11] came @ 11 - told them they were independent, told [Named Resident #81] she was brand new, he told her she still had to check them. She said 'you don't tell me what to do' 'I'll kick your ass, slamed [slammed] the bathroom door he sadi [said] '[expletive] you try it' She said '[expletive] you mother [expletive]', you can suck my ass' after confrontation . She called [Resident #56] a'mfer' [expletive] . Review of CNA #11's employee clock in and clock out for 9/14/2023 revealed the employee clocked in at 7:04 PM on 9/14/2023 and clocked out at 7:03 AM on 9/15/2023. The allegation of abuse reported by Resident #81 revealed the interaction with the employee occurred around 11:00 PM - 12:00 AM on 9/14/2023. The employee clock in and clock out revealed CNA #11 worked the remainder of the shift past the time of the allegation of the verbal abuse. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia, and Chronic Obstructive Pulmonary Disease (COPD). (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #56 was dependent for toileting, personal hygiene, and bathing which required extensive assistance of one person. During an interview on 12/19/2023 at 12:55 PM, Resident #56 stated, .[Named CNA #11] came in here about 11:00 PM [9/14/2023], my roommate asked her why she was just now checking on us. The [Named CNA #11] said she thought we could take care of ourselves. The [Named CNA #11] was standing in the bathroom, yelling, woke me up, the CNA told my roommate to suck her ass and slammed the door .I didn't trust the girl, I was afraid she would hurt us .I stayed up all night .my roommate seen her in the hall later that night .she called me a mother [expletive] .we stayed up that night because we were afraid she would come back in here . Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included Encounter for Orthopedic Aftercare following surgical amputation, Type 2 Diabetes Mellitus, Congestive Heart Failure, and Cerebral Infarction. Review of the Psychological Diagnostic Interview for Resident #81 dated 9/19/2023 revealed, .He {Resident #81] related events related to the abuse, saying that he didn't sleep the night of the event, saying he was fearful for his safety . Review of the Quarterly MDS dated [DATE] revealed Resident #81 had a BIMS score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #81 was dependent for toileting, supervision related to personal hygiene, and substantial/maximum assistance with rolling left and right, sit to lying, and lying to sitting on side of bed. During an interview on 12/19/2023 at 11:34 AM with Former DON #1 and Administrator confirmed they were notified of the allegation of verbal abuse on 9/15/2023. The Former DON #1 stated, .The written statement in the investigation was the Unit Manager's [LPN #19] statement of what [Named Resident #81] reported. The Administrator was asked if [Named Resident #56, Named Resident #81's roommate] or any other employees that worked that shift were interviewed? The Administrator stated, If I had interviewed the roommate, it would be in the investigation. I didn't ask anyone else because they were not in ear shot, I would have thought the roommate would have been interviewed. I think the roommate was interviewed by the Social Service Director [SSD]. When I called [Named CNA #11] she had an attitude with me. I just had what [Named Resident #81] reported and it was conflicted with what [Named CNA #11] said happened. I was not aware [Named Resident #81] said he didn't sleep the night of the event and was fearful for his safety. The supervisor [LPN #26] for 9/14/2023 denied knowing anything about it . The Administrator failed to follow up on documented findings that resulted in an incomplete investigation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/19/2023 at 12:20 PM, Resident #81 stated, .[Named CNA #11] threatened us, slammed the door, [Named CNA #2] another tech took care of me and my roommate the rest of the night. [Named CNA #11] never came in our room to check on us until 11:00 PM that night. When [named CNA #11] came in the room I said 'are you not supposed to check on us every 2 hours'. The CNA told me to shut up and threatened to kick my ass. I did tell her '[expletive] you' and then [Named CNA #11] said suck my ass, no one wants to take care of you, she slammed the door .I told the supervisor that night, I can't remember the supervisor's name, but the CNA wasn't sent home. I saw the CNA in the hallway about 12:00 AM and 1:00 AM. The night nurse was an agency nurse, she knew about what happened. I stayed up all night because I was scared, and my roommate was scared. I never seen anybody get that angry, they should have sent her home. I am pretty sure she worked all night. The supervisor on night shift didn't do anything. [Named CNA #11] called my roommate a 'mother [expletive]' . During an interview on 12/19/2023 at 2:17 PM, the SSD reviewed LPN #19's written statement. (the written statement was included in the facility investigation) The SSD stated, .[Named Resident #81 and Named Resident #56] pretty much said the same thing. The CNA was mean and used derogatory language and told [Named Resident #81] I'll kick your ass .I do feel this was verbal abuse .[Named Resident #56] confirmed what happened .Resident interviews are usually what I take care of in an investigation . During an interview on 1/4/2024 at 9:00 AM, (Named Resident #81) was asked when the incident occurred on 9/14/2023 how did it make him feel? (Named Resident #81) stated, .it made me angry; it made me sad because she said nobody wants to take care of me, I was dirty .needed to be changed .I told [Named CNA #27] about it .I felt apprehensive [anxious or fearful that something bad or unpleasant will happen] .scared she [CNA #11] would hit me in my sleep .we [Resident #81 and Resident #56] talked to the supervisor and the nurse .the supervisor asked me if I wanted the CNA back in here .I told her no .I told them exactly what she said to me .and my roommate heard it because she woke him up . During an interview on 1/4/2024 at 4:20 PM, LPN #18 stated, .The residents [Resident #81 and Resident #56] told me about the incident that happened the night before on 9/14/2023 .It was [Named LPN #19] I reported it to that morning .I don't remember who the nurse was that morning from night shift. The Administrator never questioned me about the incident . LPN #18 confirmed the written statement from LPN #19 was what the two residents told her as to what happened on 9/14/2023. During an interview on 1/5/2024 at 11:00 AM, the Administrator stated, .I don't see an interview with [Named LPN #21] that worked night shift [9/14/2023] .when I interviewed the CNA, judging the way she talked to me she didn't fit the model of the type of employee I felt the facility needed .It does matter to me that 2 alert residents voiced concerns about the way she talked to them .It would have been important to talk to that nurse .I came in late that day and done what I felt I needed to do .a resident should not be fearful of course not .knowing what I know today .I would have substantiated verbal abuse .I would expect my staff to intervene immediately with any abuse .and remove the employee until investigation was completed . The Administrator failed to conduct a thorough investigation and did not take immediate action to mitigate the risk of psychosocial harm (fear and anxiety) for all residents. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 1/5/2024 at 11:20 AM, LPN #19's written statement was read to LPN #19. She stated, .yes that is my statement .I was the supervisor on 9/15/2023 .[LPN #18] reported this incident to me and I went down to speak to [Named Resident #81] .I also alerted the SSD and Former DON #1 .the Administrator was also aware .the night shift nurse didn't say anything to me about the incident . During a telephone interview on 1/8/2024 at 12:10 PM, LPN #26 was asked if she was the supervisor on 9/14/2023. LPN #26 confirmed she was the supervisor. This surveyor read the statement from the facility's investigation, .Supervisor [LPN #26] in facility at time of alleged incident, had no knowledge of [Named CNA #11] cussing at resident . LPN #26 was asked if that was an accurate statement. LPN #26 stated, .absolutely not .I was notified by the tech [CNA #27] that night . During an interview on 1/8/2024 at 12:30 PM, Former DON #1 stated, .LPN #26 didn't know anything about anyone cussing the resident .[Named CNA #11] thought [Named Resident #81] was independent .[Named LPN #26] said something about switching [Named CNA #11] out but I thought it was the resident didn't want the CNA back in his room .I am not sure why the CNA was placed on another hall .

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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** 46831 Based on facility policy review, facility eINTERACT Transfer Form review, medical record review, and interview, the facility failed to communicate appropriate information to the receiving facility and ensure an effective transition of care for 1 of 1 (Resident #319) sampled residents reviewed. Resident #319 was transferred to Hospital #2 Emergency Department (ED) on 5/27/2022 for evaluation of neurological symptoms. Facility nursing staff failed to communicate information related to Resident #319's 5/26/2022 fall during both oral and written reports to Hospital #2. The findings include: Review of the facility's policy titled Transfer and Discharge Procedures, dated 12/2017 revealed, .Transfer and discharge procedures must provide sufficient preparation and orientation of the resident to ensure a safe, orderly transfer or discharge from the facility . Facility was unable to provide the policy titled Transfer and Discharge Procedures dated 2022. Review of the facility's policy titled Transfer or Discharge, Facility Initiated, dated 3/8/2023, revealed, .Should a resident be transferred or discharges for any reason, the following information is communicated to the receiving facility or provider .g) All other information necessary to meet the resident's needs .any other documentation, as applicable, to ensure a safe and effective transition of care . Review of the medical record revealed Resident #319 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Other Sequelae of Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Speech and Language Deficits following Cerebrovascular Disease. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #319 revealed, a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Review of the facility document (event/incident report) titled, Fall: Witnessed, dated 5/26/2022 at 10:18 AM, revealed, .Incident Description: Resident was lying on side receiving patient care per Certified Nursing Assistant (CNA) .to remove fecal matter .Resident grunted and moved his body like he was in pain and forcefully projected himself off of bed. Lower body was tense and appeared to be spasming . Review of the facility eINTERACT (facility document tool) Transfer Form dated 5/27/2022 at 4:47 PM revealed, Resident #319 was sent to Hospital #2 for numbness on left side of head. The Former Director of Nursing (DON) #1 completed the transfer form and Licensed Pratical Nurse (LPN) #36 called report to Hospital #2 at 4:34 PM. There was no documentation related to Resident #319's fall on 5/26/2022. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #319's progress notes dated 5/27/2022 at 4:47 PM, revealed, .pt [patient] sent out due to family request. Pt c/o [complained of] numbness on left side of head . During a telephone interview on 2/1/2024 at 3:34 PM, LPN #36 stated, .I always assisted the nurse during a transfer by calling report to the receiving facility .I used the Interact transfer form as a guide when calling report, and sent a copy of the form with the resident to the emergency room [ER] . The surveyor asked LPN #36 if information related to a fall the previous day should have been included in the report to the receiving facility. LPN #36 replied, Yes. LPN #36 stated if he had known about Resident #319's fall on 5/26/2022, he would have included it on the transfer form and in the call for report. LPN #36 stated if the information about the fall was not noted on the transfer form for Resident #319, then he was unaware of the fall. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The facility failed to ensure Hospital #2 received accurate and appropriate information related to Resident #319's fall that could have likely resulted in a delay of treatment in the ER.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44447 Based on facility policy review, review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, review of the facility incident report, facility investigation, review of Hospital #2's Emergency Department (ED) records, medical record review, and interview, the facility failed to ensure a person-centered care plan was developed and implemented for 1 of 11 (Resident #319) sampled residents reviewed using an air mattress. The facility's failure to develop and implement a person-centered care plan for Resident #319 resulted in actual harm when he fell from the bed during incontinence care and sustained a left hip fracture. The findings include: Review of the policy titled, MDS [Minimum Data Set] Assessment revised ,d+[DATE] revealed .The Purpose of the Assessment .Is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity, as well as medical, cognitive, and emotional needs .The information derived from the MDS assessment is then used to assist the staff to care plan for the resident, so the resident may achieve/maintain their highest level of daily function . The facility was unable to provide the facility policy titled Care Plans, Comprehensive Person-Centered dated 2022 . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated [DATE], revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Review of the CMS RAI Version 3.0 Manual dated ,d+[DATE] revealed, .Section G0110: Activities of Daily Living (ADL) Assistance .How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting . Review of the medical record revealed Resident #319 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Other Sequelae of Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Speech and Language Deficits following Cerebrovascular Disease and Other Seizures. Review of an Order Summary revealed, XXX[DATE] .Air Mattress-Monitor QShift [every shift] for Placement and Function XXX[DATE] .levETIRActam [anticonvulsant medication] Tablet 500 MG [milligram] two times a day for seizures . (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of the Annual MDS dated [DATE] revealed Resident #319 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Resident #319 required extensive assistance with two persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture and hygiene), total dependence with two persons physical assist for transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). Resident #319 was coded always incontinent of bowel and bladder. Resident #319 had active diagnoses which included Cerebrovascular Accident (CVA), Transient Ischemic Attack (TIA), or Stroke, Hemiplegia or Hemiparesis, Seizure Disorder or Epilepsy, Muscle Weakness, Other Lack of Coordination. Resident #319 had a pressure reducing device to the bed. Review of the care plan for Resident #319 revealed, XXX[DATE] .require assist with activities of daily living XXX[DATE] .at risk for falls r/t [related to] stroke XXX[DATE] .communicate best with yes/no questions post-stroke XXX[DATE] .chronic pain r/t Chronic Physical Disability XXX[DATE] .on an platelet inhibitor XXX[DATE] .contractures XXX[DATE] Patient to wear LLE [Left Lower Extremity] knee extension daily as tolerated XXX[DATE] air mattress monitor placement and function [no safety interventions implemented] XXX[DATE] .Bed Mobility .Total Assist x [times] 2 Staff .Transfers .Totally Dependent x 2 Staff (Mechanical Lift) XXX[DATE] Remove air mattress . Continued review revealed there was no focus or interventions for the Seizure diagnosis and no focus or interventions for risks associated with behaviors of jerking motions or spasms during care. Review of the Quarterly MDS dated [DATE] revealed Resident #319 had an unchanged BIMS score of 3, which indicated severe cognitive impairment. Resident #319 required extensive assistance with two persons physical assist for bed mobility, total dependence with two persons physical assist for transfer. Resident #319 was coded always incontinent of bowel and bladder. Review of the facility document (event/incident report) titled, Fall: Witnessed, dated [DATE] at 10:18 AM revealed, .Incident Description: Resident was lying on side receiving patient care per Certified Nursing Assistant [CNA] .to remove fecal matter .Resident grunted and moved his body like he was in pain and forcefully projected himself off of bed. Lower body was tense and appeared to be spasming .did not hit his head and denies pain anywhere other than his left knee .No injuries observed at time of incident .Level of Pain .5 .Mental Status .Lack of Safety Awareness .Predisposing Physiological Factors .Cognitive Impairment .Extremity Weakness-Upper .Communication Deficit .Extremity Weakness-Lower .Incontinent .Predisposing Situation Factors .History of Falls .Side Rails Up .No Witnesses found . The facility event incident report incorrectly stated no witnesses were found. There were two witnesses to the fall, CNA#6 and Resident 319's roommate witnessed the fall. Review of Hospital #2's ED Records for Resident #319 dated [DATE] , revealed, .CHIEF COMPLAINT .came by ems [Emergency Medical Service] from snf [Skilled Nursing Facility #1] for numbness on the top of his head for 3 days .possible stroke .HISTORY OF PRESENT ILLNESS .He states that yesterday, he was pushed off of his bed by a CNA. He hurt his left hip, low back, and hit his head .XR [Xray] Hip 2 or 3 Views Left with Pelvis .IMPRESSION: Comminuted [bone broken into more than two pieces] fracture LEFT femoral neck extending to the lesser trochanter [left hip fracture] .Impressions: the patient has a left femoral neck fracture from his fall . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of a facility investigation statement dated [DATE] revealed, .Interview with Resident #47 dated [DATE], revealed, Admin [Administration] and Social Services spoke to [Resident #47] concerning the incident. [Resident #47] said that he had witnessed his roommate fall to the floor. Resident #47 stated, .the lady [CNA#6] was changing him, and he fell . Review of a facility investigation statement dated [DATE] revealed, . [CNA #6] was asked by Admin [Administration] and Social Services to recall the incident from yesterday [[DATE]]. She stated that she was performing patient care to [Resident #319]. She said that [Resident #319] was lying horizontal on his side on the air mattress when she was attempting to wipe [bowel incontinent care]. She stated that [Resident #319] had 'jumped a little bit', enough to cause [Resident #319]'s 'legs to swing out of the bed'. During an interview on [DATE] at 3:35 PM, Former Director of Nursing (DON) #1 stated she went to Resident #319's room and completed a head-to-toe assessment when notified about the fall on [DATE]. Former DON #1 stated CNA #6 was performing incontinence care after Resident #319 had an incontinent episode, when Resident #319 slid off the bed. When asked which way CNA #6 had Resident #319 turned for incontinent care, Former DON #1 replied, [Resident #319] was turned away from [CNA #6] and when [Resident #319] started to fall, I guess [CNA #6] came around to catch him. During an interview on [DATE] at 10:17 AM, CNA #16 stated Resident #319 was incontinent and required a 2 person assist with a lift for transfers. CNA #16 stated, [Resident #319] would push back against you when he was rolled over and that's why I always used 2 people for his care, because it was safer. During an interview on [DATE] at 11:13 AM, the Occupational Therapist (OT) stated Resident #319 was on and off therapy from 2019 through 2022 and fluctuated frequently with his care. When asked about bed mobility, the OT stated this would include supine [lying face upward] to sit, which would require 2 persons assist During an interview on [DATE] at 2:00 PM, the Rehab Director was asked what was included in an assessment for bed mobility . He responded bed mobility included side to side, and sit to supine. The Rehab Director stated when a patient/resident is coded for 2-person assist for bed mobility, it would require a 2-person assist for incontinence care provided in bed. During a telephone interview on [DATE] at 9:05 AM, Licensed Practical Nurse (LPN) #4 stated she was Resident #319's nurse on [DATE]. LPN #4 stated, .I was notified by [CNA #6] that [Resident #319] had fallen off the bed .the tech (CNA #6) stated [Resident #319] was turned on his side .His body tensed up and he threw his body onto the floor .This is not the first time he had the jerking movements during care .LPN #4 stated, When I walked in the room, he was lying on the floor .It took several of us to get him up . LPN #4 was asked, did you assess [Resident #319] on the floor. She responded, He had on a gown. I did not see any deformities. I tried to do what I could of a head-to-toe assessment while he was on the floor. When asked if a lift was used to put Resident #319 back in bed, LPN #4 replied, No, three of us picked him up and placed him back in bed. LPN #4 stated, The [Former DON #1] did not come to the room after the fall and complete an assessment. LPN #4 was asked if she had been trained on providing patient care for a patient on an air mattress. LPN #4 replied, No. LPN #4 was asked if Resident #319 required seizure precautions. She responded, I don't think so. LPN #4 was asked if Resident #319 was care planned for jerking movements. LPN #4 replied, Yes, keep bed in lowest position. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	LPN #4 further stated, [CNA #6] should have requested help when [Resident #319] clinched [stiffened] up. LPN #4 was asked if there had been 2 CNAs providing incontinence care for Resident #319, would that have prevented the fall. LPN #4 replied, Yes. There were no interventions in place for jerking behaviors on the current care plan. A mechanical lift was not used to transfer Resident #319 from the floor to the bed. During a telephone interview on [DATE] at 11:02 AM, CNA #6 stated, .I was giving patient care and [Resident #319] was turned away from me .He jumped when I was cleaning his bottom .He has jumped before related to pain . CNA #6 stated, .I reached back to get some cream with one hand and kept the other hand on [Resident #319] and that's when he fell .[Resident #319] stiffened up and threw his legs off the bed . I jumped across the bed and grabbed him .[Resident #319] had jerking movements during care, that wasn't unusual. CNA #6 was asked if there had been another CNA with her while performing incontinence care on Resident #319, would that have prevented Resident #319 from falling out of the bed. CNA #6 replied, Yes, two people could have stopped him from falling .His care plan said 1 person assist . CNA #6 was asked if she was one of the 3 people that picked Resident #319 up off the floor. CNA #6 responded, Yes, we did pick him up and he was groaning from pain. During an interview on [DATE] at 12:45 PM, Former DON #1 stated the Interdisciplinary Team (IDT) investigated Resident #319's fall on [DATE] and determined the air mattress on his bed had contributed to him sliding off the bed due to him moving around and an air mattress being slick. Former DON #1 stated residents on an air mattress should have a care plan with interventions in place. When asked what type of interventions would need to be implemented, Former DON #1 replied, .check placement and functioning, and do not use fitted sheets . When asked what is meant by placement and functioning of an air mattress, the Former DON #1 replied, Placement is making sure the resident actually has the air mattress, the resident could have moved rooms and the mattress did not follow .Functioning means is the air mattress turned on, is it inflated. When asked if sheets should be used on an air mattress, the Former DON #1 replied, No, fitted sheets would prevent the mattress from properly inflating and could possibly turn off the CPR [Cardiopulmonary Resuscitation] function [This function allows for an instant deflation providing a hard surface needed for chest compressions and intubation]. Former DON #1 stated she could not think of any safety interventions that would need to be implemented for use of an air mattress. The Former DON #1 was asked if [Resident #319] had seizure precautions in place. Former DON #1 stated she was not aware of Resident #319 having a diagnosis for seizures. Former DON #1 stated she would expect his care plan to reflect a diagnosis for seizures with interventions implemented. (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:40 AM and [DATE] at 2:50 PM, the MDS Coordinator was asked to review Resident #319's quarterly assessment dated [DATE]. The MDS Coordinator was asked how she determined Resident #319 required extensive assistance of 2 persons for bed mobility, total dependence for toileting one person assist, and extensive assist of 2 persons for personal hygiene. The MDS Coordinator stated, .I would review the staffing documentation and make visual observations. If I code a resident as total assistance, then the CNA documentation must say the resident required total assistance all the time during the 7 day look back period . The MDS Coordinator was asked how Resident #319 could require 2 person assist for personal hygiene and only require 1 person assist for toileting. The MDS Coordinator stated, .I am not the CNA that cared for him so I can't tell you that . The MDS Coordinator was asked if the CNA documentation was always correct. The MDS Coordinator stated, No. The MDS Coordinator was asked if seizures were checked on Resident #319's Care Area Assessment (CAA) and Resident #319 was on seizure medication twice a day, should Resident #319 have been care planned for seizures. The MDS Coordinator responded, .Seizures should have been care planned since he was on seizure medication . The MDS Coordinator was then asked if a resident was on an air mattress, should safety measures be care planned. The MDS Coordinator stated, .I don't usually put safety measures in for an air mattress . The facility failed to implement the plan of care (2 person assistance for bed mobility/incontinent care) that resulted in Resident #319's fall out of the bed and sustained a hip fracture. The facility failed to establish interventions for the Seizure diagnosis or for risks associated with behaviors of jerking motions or spasms during care.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 facility policy review, grievance log review, medical record review, observation and interview, the facility failed to provide good grooming, incontinence care, timely call light response, and personal hygiene for 6 (Resident #4, Resident #56, Resident #81, Resident #220, Resident #221, and Resident #368) of 22 sampled residents that required assistance with personal care. The findings include: Review of the facility policy titled, .Answering the Call Light dated 5/19/2023, revealed, .The purpose of this procedure is to ensure timely responses to the resident's requests and needs .Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor . Answer the resident call system immediately .If the resident needs assistance, indicate the approximate time it will take for you to respond .If the resident's request is something you can fulfill, complete the task within five minutes .If you are uncertain as to whether or not a request can be fulfilled .ask the nurse supervisor for assistance . Review of the facility policy titled, .Bathing dated 11/28/2017 revealed, .It is the policy of the facility to make every effort to respond to the residents' requests and needs. The facility's goal is to assist the resident with maintaining as much independence as possible with their Activities of Daily Living [ADL] but providing assistance where needed and in the bathing process. It is the policy of this facility to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin during the bathing process . The facility will offer the residents baths or showers at least two (2) times each week, or more often if requested by the resident .The manner of bathing and schedule of bathing may be adjusted per resident preference and choice of care .Residents have the right to assist in determining their care, including refusal of care .resident Care Plans .updated accordingly . Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, with revision date of April 2021, revealed, .Resident have the right to be free from abuse, neglect .prevention program consists of a facility-wide commitment and resource allocation to support the following objectives . Protect residents from abuse, neglect .by anyone including, but not necessarily limited to .facility staff .staff from other agencies .Develop and implement policies and protocols to prevent and identify .abuse or mistreatment of residents .neglect of residents .Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled, .Charting/Documentation,dated 10/19/2022 revealed, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care .Documentation in the medical record may be electronic, manual or a combination .The following information is to be documented in the resident medical record .Treatments of services performed . Documentation in the medical record will be objective .complete, and accurate .Documentation of procedure and treatments will include care-specific details, including .a. the date and time the procedure/treatment was provided b. the name and title of the individual(s) who provided the care .d. how the resident tolerated the procedure/treatment e. whether the resident refused the procedure/treatment f. notification of family, physician or other staff, if indicated . Review of the facility policy titled, ADL Support, dated 5/19/2023 revealed, .Resident will be provided with care, treatment and services as appropriate to maintain or improving their ability to carry out activities of daily living .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .the resident and or representative has been informed of the risk and benefits of the proposed care or treatment .2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident .including appropriate support and assistance with .hygiene [bathing, dressing, grooming, and oral care] .4. If residents with cognitive impairment or dementia resist care, staff will attempt to identify the underlying cause of the problem and not just assume the resident is refusing or declining care. Approaching the resident in a different way or at a different time, or having another staff member speak with the resident may be appropriate . Review of the facility policy titled, ResidentRights [Resident Rights], dated 5/19/2023 revealed, .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to .a dignified existence .be treated with respect, kindness, and dignity .be free from abuse, neglect .self-determination .exercise his or her rights as a resident of the facility .be supported by the facility in exercising his or her rights .be informed about his or her rights and responsibilities .voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal .have the facility respond to his or her grievances . Review of the facility grievance logs from 2/23/2023 to 8/31/2023 and 10/1/2023 to 11/15/2023 revealed 19 resident complaints regarding slow response for call light, incontinence care not being timely, no bath in a week, and concerns related to showers. There was no grievance noted in the month of 9/2023. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant side, Essential Hypertension, and Contracture, Right hand. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan dated 11/6/2020 revealed, .Focus .I have bladder incontinence r/t [related to] Impaired Mobility .Interventions/Tasks .Check me approx [approximately] q [every] 2 hrs [hours] and as required for incontinence. Wash, rinse and dry perineum .Focus .I have bowel Incontinence r/t immobility .Interventions/Tasks .Check resident every two hours and assist with toileting as needed .Focus .I need assist with activities of daily living .Interventions/Tasks .Encourage resident to participate .Encourage resident to use call bell system for assistance .Shower/bathe .Substantial/maximal assistance x 1 staff .Toilet transfer .Substantial/maximal assistance x 1 staff . Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #4 required substantial/maximal assist with toileting, toilet transfer, and shower/bathe. Review of the electronic charting system titled [Skilled Nursing Facility SNF #1] Follow Up Question Report revealed, Resident #4 received 9 showers and 23 sponge/bedbaths from 12/1/2023 to 1/30/2024 (61 days) During an interview on 1/30/2024 at 8:30 AM, Resident #4 was asked about care at the facility. Resident #4 stated, .it depends on the CNA [Certified Nursing Assistant] you have assigned to you .some just totally ignore you .I have laid wet for 4 hours .the staff will come in turn the call light off say they will be back, and you lay and wait .a shower what is that .two 'C' words missing here at this facility, care and compassion . don't know the meaning of the words .I hate this place .don't have nothing good to say about the place . Resident #4 was asked how she tracked the time when call lights were not answered or being soiled for hours. Resident #4 pulled a clock from her overbed table and pointed at it and stated, .This is how I know . Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Cerebral Infarction, Hemiplegia, Osteomyelitis, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease (COPD) and Encounter for Palliative Care. Review of the comprehensive care plan dated 3/7/2023 revealed, .Focus Resident requires assist with activities of daily living .Interventions/Tasks .Roll left and right .Substantial/maximal assistance X 1 staff . Shower/Bathe self .Substantial/maximal assistance x 1 staff .Toileting hygiene .Substantial/maximal assistance required x 1 staff .Focus The resident has .incontinence r/t [related to] in mobility following CVA [Cerebral Vascular Accident] and amputation .Interventions/Tasks .Check the resident upon report of need to toilet or has toileted and as required for incontinence .Focus .The resident has bowel incontinence r/t .CVA and impaired mobility .Interventions/Tasks .Check resident every two hours and assist with toileting as needed . Review of the Quarterly MDS dated [DATE] revealed Resident #56 had a BIMS score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #56 was dependent for toileting, personal hygiene, and bathing which required extensive assistance of one person. Review of the electronic charting system titled [SNF #1] Follow Up Question Report revealed, Resident #56 received 2 showers and 19 sponge/bedbaths from 11/6/2023 to 1/4/2024 (59 days). (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 12/19/2023 at 12:55 PM, Resident #56 was in the bed. Resident #56's fingernails were long and dirty. Resident #56 was asked when he had received a shower. Resident #56 stated, .I couldn't tell you the last time I received a shower .they may take a wipe and wash me that way but no shower .the staff always has an excuse .I have complained .doesn't really do any good .I like to be clean shaven .my family comes in to shave me .I am often wet, and I will have to wait hours .staff will come in answer the light and say they will be back, and I never see them again. I have called my family at times because I was wet . During an observation and interview on 1/5/2024 at 10:30 AM, Resident #56 was in bed and continued to have long dirty fingernails, a mustache and beard. During an interview on 1/23/2023 at 10:15 AM, The Interim Director of Nursing (IDON) was asked when (Named Resident #56)'s shower was scheduled. The IDON stated, Monday and Thursday on 7PM-7AM shift 2 times a week. The IDON was asked to review the electronic charting system sheet named Follow Up Question Report for bathing/shower dated 11/6/2023-1/5/2024. The IDON confirmed only 2 showers were documented from 11/6/2023-1/5/2024 on 12/7/2023 and 12/21/2023. The IDON stated, The CNAs do paper documentation for showers sometimes. The IDON was asked should the electronic charting where CNAs chart, match the shower sheets and the IDON stated, yes, they should match. During an interview on 1/24/2024 at 2:58 PM, Family Member (FM) #31 stated, .It has been 3 weeks at a time that [Named Resident #56] goes without a shower .I come in about every 2 weeks to shave him and cut his hair because they don't shave him .I have been at the facility when he would be soiled, and he waited 3 hours to be changed .I have talked to the Administrator several times .it's been at least 2 weeks since he has been out of the bed .I filed a complaint with the state about his care . During an interview on 1/30/2024 at 3:38 PM, the Administrator was asked if he recalled FM #31 filing a grievance in relation to [Named Resident #56]'s care. The Administrator provided a grievance dated 11/4/2023 which revealed, COMPLAINT .CNA .was very rushed and did not change him gently. He said his head was up against the siderail. She had a sour attitude with him .INVESTIGATION STEPS AND FINDINGS: Employee was immediately re-assigned for additional oversight and coaching and she left the facility and self-terminated .FINAL DISPOSITION AND CORRECTIVE ACTION: Employee was coached and opted to resign .The grievance form was signed by Resident #53. The Administrator stated, .this is all I could find related to grievance from the resident . Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnoses which included Encounter for Orthopedic Aftercare following surgical amputation, Type 2 Diabetes Mellitus, and Congestive Heart Failure. Review of the Quarterly MDS dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #81 was dependent for toileting, supervision related to personal hygiene, and substantial/maximum assistance with rolling left and right, sit to lying, and lying to sitting on side of bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan dated 11/24/2023 for Resident #81 revealed, Focus Resident requires assist with activities of daily living Date inititiated: 05/11/2023 .Interventions/Tasks .Toileting hygiene .Dependent x 1 staff .Tub/Shower .Dependent x 2 staff .Focus Abuse/Neglect: I'm at risk for actual/potential abuse/neglect related to my dependence on others for ADL [Activities of Daily Living] care .Goal I will not experience any form of abuse or neglect through review date .Interventions/Tasks Provide assistance with ADL's as needed .Provide support and ensure resident is free from abuse and/or neglect .Focus Trauma Informed Care/Stressful Life Experience .I may have trauma related stress related to loss of independence and living in a nursing facility .Goal I will verbalize a sense of control and safety .Interventions/Tasks Actively listen to resident as they describe life stresses .Encourage verbalization of feelings, perceptions, and fears . Identify and avoid triggers for stresses . Further review of the comprehensive care plan dated 12/1/2023 revealed, Focus The resident has mixed bladder incontinence .Interventions/Tasks .Check the resident (FREQ) [Frequently] and as required for incontinence .Focus The resident has bowel incontinence r/t immobility .Interventions/Tasks .Provide pericare after each incontinent episode . Review of the electronic charting system titled [SNF #1] Follow Up Question Report revealed, Resident #81 received 0 showers and 20 sponge/bedbaths from 11/6/2023 to 1/4/2024 (59 days) During an observation and interview on 12/19/2023 at 12:20 PM, Resident #81 was noted to have dry flaky skin to his scalp, his hair looks oily, and unkempt. Resident #81 had dried food on his t-shirt, his nails were dirty, and his beard had flakes, which appeared to be flaky dry skin. Resident #81 was asked when he last received a shower. Resident #81 stated, .I really can't tell you when I have had a shower .the staff sponge me off a couple of times a week, but I really wouldn't call it a bath . Resident #81 had stains on his pillowcase and sheet. During an observation and interview on 1/4/2024 at 9:00 AM, Resident #81 continued to have flaky oily hair, flakes in his beard which appeared to be dry flaky skin, fingernails continued to be dirty, and resident's t-shirt was dirty. Resident #81 was asked if he had a shower or been up since 12/19/2023. Resident #81 stated, .no shower .I am supposed to get it on Monday and Thursday .I have asked to be up, but I continue to lay in the bed . During an observation and interview on 1/5/2024 at 10:15 AM, Resident #81 continued to appear disheveled, hair continued to be oily with dry flakes noted in hair and beard. Resident #81 continued to wear the same dirty t-shirt he had on 1/4/2024. Resident #81 was asked if he had received a shower. Resident #81 stated, . No shower .I received incontinence care around 9:00 AM .it doesn't do any good to ask about a shower, usually not enough staff . During an observation and interview on 1/5/2024 at 11:30 AM, Resident #81 continued to have flaky oily hair with flakes in his beard. Resident #81 had dirty fingernails and continued to have on the same dirty t-shirt he had on 1/4/2024. Resident #81 stated, .didn't get my bath .I wasn't offered one .no bed bath, no shower or nothing .my hair hasn't been washed since I went to the barber shop and got it cut .I think maybe 2 months ago .they don't take care of us . Resident #81 was asked about answering of his call light and incontinence care. Resident #81 stated, .we wait hours for our lights to be answered .sometimes the staff will ask what we need turn the light off and they never come back .it is according to who the CNA is whether you get help or lay in urine for hours .I have had to lay in feces for hours .don't do any good to complain . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 1/8/2024 at 8:50 AM, Resident #81 was sitting in his wheelchair in the front lobby. Resident #81 stated, I am waiting on transportation to go to the doctor. Resident #81's hair continued to be flaky and oily. Resident #81's fingernails continued to be dirty. Resident #81 had on shorts, a dirty t-shirt and a coat. Resident #81 continued to appear unkempt. During an interview on 1/9/2024 at 2:35 PM, Licensed Practical Nurse (LPN) #18 stated, .[Named Resident #81] came back from his doctor's appointment yesterday, he was complaining at the doctor about being short of breath and we sent him to the hospital. I think the hospital said he was in fluid overload . During an interview on 1/23/2024 at 9:06 AM, Regional Nurse Consultant #1 obtained the History and Physical for Resident #81's admission to the hospital and stated, Now it says in the report he was not getting up and receiving baths but he is very non-compliant. During an interview on 1/23/2024 at 11:00 AM, the Regional Nurse Consultant #1 stated, We offer showers 2 times per week. The Regional Nurse Consultant #1 was asked to review the documentation for his showers and if she noted any refusals from 11/7/2024 to 1/4/2024. The Regional Nurse Consultant #1 stated, No. During an interview on 1/23/2024 at 11:20 AM, Certified Nursing Assistant (CNA) #22 was asked how often the residents had showers scheduled. CNA #22 stated, .The showers should be done 2 times per week. I will be honest with you the night shift doesn't follow the shower schedule or do the showers. Management just don't crack down on them . CNA #22 was asked where a CNA should chart a shower when it had been completed. CNA #22 stated, .It should be documented in the computer system . Review of Hospital #6 History and Physical form 1/8/2024 for Resident #81 noted, XXX[AGE] year old male with history of hypertension, diabetes, CAD [Coronary Artery Disease] s/p [status post] CABG [Coronary Artery Bypass Surgery] who presents from his skilled nursing facility with volume overload and dyspnea. Patient was seen in the vascular clinic earlier today for a scheduled appointment and was told to come here because of his worsening edema [swelling caused by too much fluid trapped in the body's tissues]. He reports intermittent shortness of breath at rest .He reports that they (Named Skilled Nursing Facility SNF #1) . have not given him a bath or shower in 1 to 2 months, exam is consistent with this .Discharge Planning: admitted as inpatient for acute heart failure exacerbation. Will need new skilled nursing facility placement at discharge, case management consulted . Review of the medical record revealed Resident #220 was admitted to the facility on [DATE] with diagnoses which included Urinary Tract Infection, Unspecified Fall, and Type 2 Diabetes Mellitus. Review of the Admission MDS dated [DATE] revealed a BIMS score of 14, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #220 required substantial/maximal assistance with toileting and shower/bathe and supervision or assistance with personal hygiene. Further review of the MDS revealed resident was at risk for developing pressure ulcers. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the comprehensive care plan for Resident #220 revealed, .Focus Resident requires assist with activities of daily living .Interventions/Tasks Assist with bed mobility .toileting .and bathing as required . Encourage resident to participate to the fullest extent possible with each interaction .Encourage resident to use call bell system for assistance .Toileting hygiene .Substantial/maximal assistance required x 1 staff . Shower/bathe self .Substantial/maximal assistance x 1 staff .Toilet transfer .Supervision .required . Tub/shower transfer .Supervision .assistance required .No Male CNA for Direct Care . Review of the electronic charting system titled [SNF #1] Follow Up Question Report revealed, Resident #220 received 10 showers and 14 sponge/bedbaths from 12/1/2023 to 1/30/2024 (61 days). During an observation and interview on 1/30/2024 at 8:20 AM, Resident #220 was asked how often do you receive a shower. Resident #220 stated, .I think I have had a few showers since I have been here but usually it is just a sponge off in the bed .I believe it was a week ago when my hair was washed .I would like to take my showers instead of a bed bath . Review of the medical record revealed Resident #221 was admitted to the facility on [DATE] with diagnoses which included Unspecified Trochanteric Fracture of Left Femur, and Type 2 Diabetes Mellitus. Review of Resident #221's baseline care plan dated 1/26/2024 revealed, .Resident requires assist with activities of daily living r/t (related to) recent hospital stay .Interventions/Tasks .Assist with bed mobility, transfers, toileting, and bathing . Review of the Occupational Therapy (OT) Treatment Encounter Note dated 1/29/2024 revealed, . Precautions Details: NWB [Non Weight Bearing] (L) [Left] LE [lower extremity] . During an interview on 1/30/2024 at 1:00 PM, Resident #221 was asked about his care at the facility. Resident #221 stated, .can't get no help around here .I have broke my hip and I need help going to the bathroom. I am not suppose to bear all my weight on my left leg. I can't sit and wait and wait for someone to help me to the bathroom cause I will wet or mess on myself. I just have to go on with my walker and sometimes I have to bear my weight to get to the bathroom. The call light just goes off and you have to wait, sometimes an hour . Review of the medical record revealed Resident #368 was admitted to the facility on [DATE] with diagnoses which included Spondylopathy (disorder of the vertebrae), Pain, Dorsalgia (pain in the back), and Contracture of Muscle Left Lower leg. Review of the comprehensive care plan dated 12/14/2023 for Resident #368 revealed, .Focus Resident requires assist with activities of daily living r/t recent hospital stay .Interventions/Tasks .Assist with bed mobility, transfers, toileting, and bathing as required .Encourage resident to use call bell system for assistance .Toileting hygiene .Substantial/maximal assistance required .Shower/bathe self . Substantial/maximal assistance Tub/Shower transfer .Dependent x 2 staff .Focus The resident has a Condom catheter .Goal The resident will show no s/sx [signs/symptoms] of Urinary Infection . Interventions/Tasks .Focus The resident has pressure ulcer .Left ischium stage III .Reopened 1-24-24 .Goal The resident's .Pressure ulcer will show signs of healing and remain free from infection by/through review date . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Admission MDS dated [DATE] revealed a BIMS score of 15, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #368 required substantial/maximal assistance with toileting and shower/bathe and supervision/ assistance with personal hygiene, an external catheter and occasionally incontinent of urine and frequently incontinent of bowel, a stage 2 and stage 3 pressure ulcer present over the last 7 days. Review of the electronic charting system titled [SNF #1] Follow Up Question Report revealed, Resident #368 received 1 shower and 16 sponge/bedbaths from 12/13/2023 to 1/30/2024 (48 days). During an interview on 1/30/2024 at 1:10 PM, Resident #368 was asked how often do you receive a shower. Resident #368 stated, .No showers since I been here .I just get a bed bath .I think the last one was a month ago .you set in your feces for hours .you say anything about it they label us like troublemakers .if you keep complaining they will write you up put it in your records .CNAs will say this room is a problem .not compassionate .the staff will come in find out what you need tell you someone is coming then turn the light off .the supervisors want to be friends with the CNAs not manage them .

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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 review, and interview, the facility failed to administer medications as ordered by the physician for 3 (Residents #32, Resident #370 and #372) of 28 residents reviewed. The findings include: Review of the facility policy titled, Administering Medication, dated 4/28/2022 revealed, .Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders .If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's Attending Physician or the facility's Medical Director to discuss the concerns . Review of the medical record revealed Resident #321 was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis, Nondisplaced Bicondylar Fracture of Right Tibia, and Displaced Oblique Fracture of Shaft of Right Femur. Review of the admission orders dated 7/11/2023 revealed Resident #321 had the following orders: Baclofen oral tablet 10mg, give 1 tablet by mouth three times a day for muscle spasms, Bumetanide tablet 2mg (milligram) give 1 tablet by mouth 2 two times a day for fluid retention, Calmoseptine external ointment 0. 44-20.6 %, Apply to sacrum topically three times a day for protection, CellCept tablet 500mg, give 2 tablet by mouth one time a day for immunosuppression, Chlorhexidine Gluconate mouth/throat solution 0.12%, give 15ml by mouth in the morning for prevention swish and spit, Fluticasone Propionate nasal suspension 50 mcg/ACT, 1 spray in both nostrils two times a day for allergies, Duloxetine HCL (Hydrochloride) capsule delayed release particles 30mg, give 1 capsule by mouth one time a day for depression, Empagliflozin oral tablet 10mg, give 1 tablet by mouth one time a day for diabetes, Losartan Potassium tablet 100mg, give 1 tablet by mouth one time a day for hypertension, multiple vitamin tablet, give 1 tablet by mouth one time a day for vitamin supplementation, Nystop external powder 100000 UNIT/GM (gram), apply to affected area as directed topically one time a day for skin infection, Omeprazole oral capsule delayed release 40mg, give 1 capsule by mouth one time a day for acid indigestion, Oxcarbazepine tablet 300mg, give 1 tablet by mouth one time a day for trigeminal neuralgia, Senna S oral tablet 8.6-50mg, give 2 tablet by mouth two times a day for constipation for 10 days, and Spironolactone tablet 25 mg, give 2 tablet by mouth one time a day for hypertension and heart failure. Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed, a BIMS score of 12, which indicated moderate cognitive impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Medication Administration Record (MAR) for July 2023, revealed Resident #321 had missing 6:00 AM medications/treatments: Cellcept tablet 500mg, give 2 tablets by mouth in the morning for immunosuppression, Chlorhexidine Gluconate Mouth/Throat solution 0.12%, give 15ml by mouth in the morning for prevention, Duloxetine HCL capsule delayed release particles, give 1 capsule by mouth a time a day for depression, Empagliflozin oral tablet 10mg, give 1 tablet by mouth 1 time a day for diabetes, Losartan Potassium tablet 100mg, give 1 tablet by mouth one time a day for hypertension, multiple vitamin tablet, give 1 tablet by mouth one time a day for vitamin supplementation, Nystop external powder 100,000 Unit/GM, apply to bilateral breast fold topically one time a day for skin infection, Omeprazole oral capsule delayed release 40mg, give 1 capsule by mouth in the morning for GERD, Oxcarbazepine tablet 300mg, give 1 tablet by mouth one time a day for Trigeminal Neuralgia, Spironolactone tablet 25mg, give 1 table by mouth one time a day for hypertension and heart failure, Bumetanide tablet 2mg, give 1 tablet by mouth two times a day for fluid retention, Fluticasone Propionate Nasal Suspension 50mcg/ACT (microgram/actuation), 1 spray in both nostrils two times a day for allergies, Senna S Oral Tablet 8.6-50 mg, give 2 tablet by mouth two times a day for constipation for 10 days starting 7/12/2023, Baclofen oral tablet 10mg, give 1 tablet by mouth three times a day for muscle spasms, and Calmoseptine external ointment 0.44-20.6%, apply to sacrum topically three times a day for protection. Resident #321 did not receive 14 medications as ordered by the physician on 7/15/2023 at 6:00 AM. Review of the Progress Notes dated 7/15/2023, revealed no documentation explaining why medications had not been administered. During an interview on 12/20/2023 at 11:36 AM, Family Member (FM) #1 stated she had concerns with (Named Resident #321) missing medications. FM#1 was informed by Resident #321 that she had not received her morning medications. FM#1 called the facility and spoke with the nurse (LPN #31) on the morning shift. LPN#31 stated that the night shift nurse (LPN #46) had not given Resident #321 medications that morning on 7/15/2023. During an interview on 1/9/2024 at 4:00 PM, Registered Nurse (RN) #8 was asked if she remembered a time when multiple residents did not receive their medication on the first floor. RN#8 stated yes. RN #8 stated when she arrived on 100 unit hall, she was given report from LPN #46 (the off-going night nurse). LPN #46 stated since she was the only nurse on the 100 unit hall on 7/14/2023 on the 7:00PM to 7:00 AM shift, she was not able to administer all the medications to every resident. RN #8 attempted to complete some of the 7:00 AM medications left from the previous shift but was not able to complete all of them due to time constraints. During an interview on 1/9/2024 at 4:25 PM, LPN #31 stated the off-going nurse (LPN #46), appeared frazzled. LPN #31 stated when she looked at the computer the nurse (LPN #46) was still signed in and she could see all the past due items (medications) that were still showing up on the computer screen for the 100 unit hall. Review of the medical record revealed Resident #370 was admitted on [DATE] with diagnoses which included Cellulitis of Left Lower Limb and Methicillin Resistant Staphylococcus Aureus Infection. Review of the admission orders for Resident #370 dated 10/19/2023, revealed the following medication were ordered upon admission: Dupixent (a medication used to treat an inflammatory response) 300mg/2ml (milliliters) pen injector, inject 300mg under the skin every 14 days. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the admission MDS for Resident #370 dated 10/26/2023 revealed a BIMS score of 13, which indicated no cognitive impairment. Continued review revealed Resident #370 received an injection 1 time during the 7-day look back period. Review of the MARs for October, November, and December 2023 revealed Dupixent was not administered to Resident #370 on 11/17/2023 or 12/1/2023. Review of the MAR revealed the nurse documented 9 on 11/17/2023 and 12/1/2023, which meant see nurses notes. Review of the Progress Notes for Resident #370 dated 11/17/2023 and 12/1/2023 revealed no nurses note explaining the reason Dupixent was not administered. During an interview on 12/13/2023 at 2:53 PM, LPN #11 stated she did not administer the Dupixent injection to Resident #370 on 11/17/2023 or 12/1/2023 because the medication was not available. When asked the process to be followed when a medication is not available, LPN #11 stated she should call the pharmacy or Nurse Practitioner (NP) for further instructions. LPN #11 stated she called the pharmacy and told them the medication was not available, and she was told the pharmacy would send it out on the next delivery. LPN #11 stated, I don't believe it ever came in .You don't skip giving meds .I don't remember following up on it .I didn't do the follow through . During an interview on 12/18/2023 at 1:20 PM, the Director of Nursing (DON) stated she would expect the nurse to notify the pharmacy or the clinician if an ordered medication is not available, and there should be an order to hold the medication or change it to a similar medication. The DON stated it is not acceptable for a resident to miss a medication. Review of the medical record revealed Resident #372 was admitted to the facility on [DATE] with diagnoses which included infection and inflammatory reaction due to Unspecified Internal Joint Prosthesis, and Primary Hypertension. Review of the admission orders dated 10/4/2023, revealed the following medications were ordered: . Cefepime-Dextrose Intravenous Solution Reconstituted .every 8 hours for sepsis until 11/9/2023 . Review of the MARs for October and November 2023 revealed, .10/4/2023 Cefepime-Dextrose Intravenous (IV) Solution Reconstituted .use 2000 mg intravenously every 8 hours for sepsis until 11/9/2023 . Continued review revealed the first dose was administered on 10/4/2023 at 10:00 PM, and the last dose was administered on 10/22/2023 at 2:00 PM. Continued review of the MAR revealed, .10/22/2023 Cefepime HCL 2 GM/100ML .Use 2 Grams intravenously every 8 hours for sepsis until 11/9/2023 . Continued review revealed the first dose was administered on 11/29/2023 at 2:00 PM and continued to be administered through the end of the month. Cefepime was not administered from 10:00 PM on 11/22/2023 through 10:00 PM on 11/29/2023. The resident missed 22 consecutive doses of the IV antibiotic for sepsis. (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 1/2/2024 at 2:00 PM, RN #3 stated the floor nurse came to her and said the IV antibiotic, Cefepime, for Resident #372 was reconstituted with normal saline and the order stated it was to be reconstituted with Glucose. RN #3 stated she called the Nurse Practitioner (NP #2) and told him the Cefepime on hand was mixed with normal saline and the order called for glucose. She stated NP #2 told her he would look into it and let her know what to do. She stated he gave the order to discontinue the Cefepime and he would take care of it from there. RN #3 stated NP #2 always put his own orders into the electronic medical record system. RN #3 stated she was not aware Resident #372 did not receive her IV Cefepime for 8 days. During an interview on 1/2/2024 at 3:30 PM, the Regional Nurse Consultant #1 and the DON reviewed Resident #372's MAR dated 10/1/2023-10/31/2023. Both agreed the MAR revealed the Cefepime medication was not administered to Resident #372 on 10/22/2023 at 10:00 PM through 10/29/2023 at 2:00 PM. During an interview on 1/2/2024 at 3:45 PM, the Medical Director stated he did not know why Resident #372 did not receive her IV Cefepime from 10/22/2023 until 10/29/2023. During an interview on 1/9/2024 at 12:15 PM, NP #2 stated he meant to re-order the Cefepime for Resident #372. NP #2 stated a nurse brought to his attention the fact Resident #372 had gone a week without the Cefepime being administered. NP #2 stated the fact Resident #372 didn't get the IV Cefepime for 22 doses, was a mistake. 47127

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F 0689 Level of Harm - Actual harm 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** 44724 46831 Based on facility policy review, review of the Centers for Medicare and Medicaid Services (CMS) Resident Assessment Instrument (RAI) Version 3.0 Manual, facility eINTERACT Transfer Form review, medical record review, facility investigation review, and interview, the facility failed to provide an environment that is free from accident hazards over which the facility has control and provide supervision for 1 of 11 (Resident #319) sampled residents reviewed for assistance with Activities of Daily Living (ADL)s and air mattress use. The facility's failure to provide a safe environment during care resulted in actual harm when Resident #319 fell from bed and sustained a left hip fracture on [DATE] while receiving incontinence care with use of 1 person assist. The findings include: Review of the facility's policy titled, .Fall Management revised ,d+[DATE] revealed, .The facility assists each resident in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices and/or functional programs, as appropriate, to minimize the risk for falls. The Interdisciplinary Team (IDT) evaluates each resident's fall risk. A care plan is developed and implemented, based on this evaluation, with ongoing review .When a fall occurs, the resident is assessed for injuries by the nurse .Complete an Incident/Accident Report .Complete SBAR [Situation, Background, Assessment, and Recommendation] Communication Form & Progress Note .Add the fall event to 24-Hour Report .Initiate the Interdisciplinary Post-Fall Review .communicates resident falls to the attending physician . will discuss recommended interventions to reduce the potential for falls for the resident .IDT reviews all falls within ,d+[DATE] hours .IDT designee will discuss recommended significant changes .care plan will be reviewed and/or revised as indicated . Review of the CMS RAI Version 3.0 Manual dated ,d+[DATE] revealed, .Section G0110: Activities of Daily Living (ADL) Assistance .How a resident turns from side to side, in the bed, during incontinence care, is a component of Bed Mobility and should not be considered as part of Toileting . Review of the facility's policy titled MDS [Minimum Data Set] Assessment, revised ,d+[DATE] revealed, .The Purpose of the Assessment .Is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity, as well as medical, cognitive, and emotional needs . The information derived from the MDS assessment is then used to assist the staff to care plan for the resident, so the resident may achieve/maintain their highest level of daily function . Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, dated [DATE], revealed .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center for Rehabilitation and Healing	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's policy titled, Accidents Incidents Investigating, dated [DATE] revealed, .All accidents or incidents involving residents .occurring on our premises shall be investigated and reported to the administrator .b. The nature of the injury/illness .c. The circumstances surrounding the accident or incident . k. Any corrective action taken . Review of the medical record revealed Resident #319 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Other Sequelae of Cerebral Infarction, Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left Non-Dominant Side, Speech and Language Deficits following Cerebrovascular Disease and Other Seizures. Review of the Physician's Orders revealed, XXX[DATE] .Air Mattress-Monitor QShift [every shift] for Placement and Function XXX[DATE] .levETIRActam [anticonvulsant medication] Tablet 500 MG [milligram] two times a day for seizures . Review of the Fall Risk Evaluation dated [DATE], revealed Resident #319 was scored high risk for falls. Review of the Quarterly MDS dated [DATE] revealed Resident #319 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Resident #319 required extensive assistance with two persons physical assist for bed mobility (how resident moves to and from lying position, turns side to side, and positions body while in bed or alternate sleep furniture and hygiene), total dependence with two persons physical assist for transfer (how resident moves between surfaces including to or from: bed, chair, wheelchair, standing position (excludes to/from bath/toilet). Continued review revealed Resident #319 was always incontinent of bowel and bladder. Review of Resident #319's Fall Risk Evaluation dated [DATE], revealed, Former DON #1 documented, . Reason for Assessment Request .Recent Falls .Gait Analysis .Unable to independently come to a standing position .Exhibits loss of balance while standing .Requires hands on assistance to move from place to place . Decrease in muscle coordination . Review of the care plan revealed, XXX[DATE] .at risk for falls r/t [related to] stroke XXX[DATE] .on an platelet inhibitor XXX[DATE] .communicate best with yes/no questions post-stroke XXX[DATE] .chronic pain r/t Chronic Physical Disability XXX[DATE] .contractures XXX[DATE] .require assist with activities of daily living XXX[DATE] air mattress monitor placement and function XXX[DATE] Patient to wear LLE [left lower extremity] knee extension daily as tolerated XXX[DATE] .Bed Mobility .Total Assist x [times] 2 Staff XXX[DATE] Transfers .Totally Dependent x 2 Staff (Mechanical Lift) . Continued review revealed there was no Focus/Interventions for a seizure diagnosis, no focus for risks associated with involuntary jerking motions and/or spasms during care, and no safety interventions related to use of an air mattress. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility document (event/incident report) titled, Fall: Witnessed, dated [DATE] at 10:18 AM, revealed, .Incident Description: Resident was lying on side receiving patient care per Certified Nursing Assistant (CNA) .to remove fecal matter .Resident grunted and moved his body like he was in pain and forcefully projected himself off of bed .Lower body was tense and appeared to be spasming .did not hit his head and denies pain anywhere other than his left knee .No injuries observed at time of incident .Level of Pain .5 .Mental Status .Lack of Safety Awareness .Predisposing Physiological Factors .Cognitive Impairment .Extremity Weakness-Upper .Communication Deficit .Extremity Weakness-Lower .Incontinent .Predisposing Situation Factors .History of Falls .Side Rails Up .No Witnesses found . The incident description described above was incorrect. There were two witnesses present in the room at the time of the fall. Review of the facility eINTERACT Transfer Form, dated [DATE] at 4:47 PM revealed, Resident #319 was sent to Hospital #2 for numbness on left side of head. Resident Representative (Family Member-FM #14) and Medical Director (MD) were notified. Former DON #1 completed the transfer form and Licensed Practical Nurse (LPN) #36 called report to Hospital #2 at 4:34 PM. There was no documentation on the transfer form related to Resident #319's fall on [DATE]. Review of Hospital #2's Emergency Department (ED) Records for Resident #319 dated [DATE] revealed, . CHIEF COMPLAINT .came by ems [Emergency Medical Services] from snf [Skilled Nursing Facility #1] for numbness on the top of his head for 3 days .possible stroke .HISTORY OF PRESENT ILLNESS .He states that yesterday, he was pushed off of his bed by a CNA. He hurt his left hip, low back, and hit his head .XR [Xray] Hip 2 or 3 Views Left with Pelvis .IMPRESSION: Comminuted [bone broken into more than two pieces] fracture LEFT femoral neck extending to the lesser trochanter [left hip fracture] .Impressions the patient has a left femoral neck fracture from his fall . Review of the employee record for CNA #6 revealed no documented training for Activities of Daily Living (ADL) Care. Review of a facility investigation statement dated [DATE] revealed, .Interview with [Named Resident #319]: Admin [Administrator] and Social Services asked [Resident #319] to recall the incident he had spoken to [FM-Family Member #14] about. He [Resident #319] recounted that the day prior he was sitting upright on the side of his bed when a tech came in and pushed him from behind off the side of the bed and he fell to the floor. Patient [Resident #319] could not recall why the tech was in his room but stated that he felt like it was an intentional act .[Resident #319] was asked to show how this incident occurred. Social Services [SSD #1] turned her back to [Resident #319] and [Resident #319] placed both of his hands in a cupping motion underneath Social Service's armpits and made a pushing motion away from [Resident #319]'s body . Resident #319 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #319 had hemiparesis to his left extremities and his left hand was contracted. The two witnesses in the room at the time of incident, reported conflicting accounts related to the fall. The facility provided no documentation to substantiate the details provided in the above facility investigation statement. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a facility investigation statement dated [DATE] revealed, .Interview .Admin [Administrator] and Social Services spoke to [Named Resident #47] concerning the incident .[Resident #47] said that he had witnessed his roommate fall to the floor with the staff member .He relayed that no pushing happened and that the lady was changing him and he fell . Review of a facility investigation statement dated [DATE] revealed, .[CNA #6] was asked by Admin and Social Services to recall the incident from yesterday .She stated that she was performing patient care to [Named Resident #319] .She said that [Resident #319] was lying horizontal on his side on the bed when she was attempting to wipe [Resident #319] .She stated that [Resident #319] had jumped a little bit, enough to cause [Resident #319]'s legs to swing out of the bed. She said that she could see that [Resident #319] was going to fall off the bed so she put her arms underneath his and assisted him to the floor. During an interview on [DATE] at 4:05 PM, FM #14 (Resident #319's significant other) stated, .[Named Resident #319] can't walk or sit up .[SNF #1] called me and said [Resident #319] fell . They said the CNA caught him .I asked his roommate [Resident #47] if [Resident #319] had hit the floor and [Resident #47] said 'yes he did' .I asked [SNF #1] if [Resident #319] had any broken bones and did they do X-rays .[SNF #1] said 'no' .I went to see [Resident #319] the next day and he was crying because he was in so much pain .I called the paramedic to take him to [Hospital #2] ER .[Resident #319] had a broken hip .[Hospital #2] did surgery on his hip the next day . During an interview on [DATE] at 3:35 PM, Former DON #1 stated she went to Resident #319's room and completed a head-to-toe assessment when notified about the fall on [DATE]. Former DON #1 stated, .When I entered the room, [Resident #319] was in a sitting position or maybe propped up against something . [Resident #319] rated his pain 5 of 10 his left knee hurt but that was his bad knee. [Resident #319] told me to just put him back in bed . When asked if Resident #319 was provided an intervention for pain rated 5 of 10, Former DON #1 replied, .[Resident #319] refused pain medication for pain in his knee and just wanted to be put back in bed . Former DON #1 stated CNA #6 and LPN #4 were in the room and used a mechanical lift to place Resident #319 back in the bed. Former DON #1 stated CNA #6 was performing incontinence care after Resident #319 had an incontinent episode when Resident #319 slid off the bed. When asked which way CNA #6 had Resident #319 turned for incontinence care, Former DON #1 replied, [Resident #319] was turned away from [CNA #6] and when [Resident #319] started to fall, I guess [CNA #6] came around to catch him. Former DON #1 stated the CNAs are able to look at the Kardex for information involving residents' care plans. Former DON #1 was asked if nursing had documented Resident #319's continuing assessment for changes post fall in the progress notes for Resident #319. She responded No. During interview with LPN #4 and CNA #6, they both denied Former DON #1 was present in the room after Resident #319's fall. LPN #4 and CNA #6 stated no lift was used to place Resident #319 back in bed. During an interview on [DATE] at 10:17 AM, CNA #16 stated Resident #319 was incontinent and required a 2 person assist with a lift for transfers. CNA #16 stated, [Named Resident #319] would push back against you when he was rolled over and that's why I always used 2 people for his care, because it was safer. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:00 PM, the Rehab Director was asked what was included in assessment for bed mobility. He responded bed mobility had a wide range which included side to side and sit to supine. The Rehab Director stated when a patient/resident is coded for 2-person assist for bed mobility, it would require a 2-person assist for incontinence care provided in bed. During a telephone interview on [DATE] at 9:05 AM, LPN #4 stated she was Resident #319's nurse on [DATE]. LPN #4 stated, .I was notified by [CNA #6] that [Named Resident #319] had fallen off the bed .the tech [CNA #6] stated [Resident #319] was turned on his side .His body tensed up and he threw his body onto the floor .This is not the first time he had the jerking movements during care .[Resident #319] said I don't know why I do this .LPN #4 stated, When I walked in the room, he was lying on the floor .It took several of us to get him up . LPN #4 was asked, did she assess Resident #319 on the floor. She responded, He had on a gown. I did not see any deformities. I tried to do what I could of a head-to-toe assessment while he was on the floor. When asked if a lift was used to put Resident #319 back in bed. LPN #4 replied, No, three of us picked him up and placed him back in bed. LPN #4 stated the DON #1 did not come to the room after the fall and complete an assessment. LPN #4 was asked if she had been trained on providing patient care on an air mattress. LPN #4 replied, No. LPN #4 was asked if Resident #319 required seizure precautions. She responded, I don't think so. LPN #4 was asked was Resident #319 care planned for jerking movements. LPN #4 replied, Yes, keep bed in lowest position. LPN #4 stated [CNA #6] should have requested help when Named Resident #319] clinched [stiffened] up. LPN #4 was asked if there had been 2 CNAs providing incontinence care for Resident #319, would that have prevented the fall. LPN #4 replied, Yes. The facility was unable to provide documentation of any assessments performed related to Resident #319's fall on [DATE]. During a telephone interview on [DATE] at 11:02 AM, CNA #6 stated, .I was giving patient care .[Named Resident #319] was turned away from me .He jumped when I was cleaning his bottom .He has jumped before related to pain .I reached back to get some cream with one hand and kept the other hand on [Resident #319] and that's when he fell .[Resident #319] stiffened up and threw his legs off the bed .I jumped across the bed and grabbed him under his arms and lowered him to the floor .[Resident #319] had jerking movements during care, that wasn't unusual. CNA #6 was asked if she had another CNA [2-person assist] with her while performing incontinence care on Resident #319, would that have prevented Resident #319 from falling out of the bed. CNA #6 replied, Yes, two people could have stopped him from falling .His care plan said 1 person assist . CNA #6 was asked if she was one of the three people that picked Resident #319 off the floor. CNA #6 responded, Yes, we did pick him up and he was groaning from pain. During an interview on [DATE] at 11:16 AM, FM #14 stated, .[Resident #319] is paralyzed on the left side. FM #14 was asked if she had Resident #319 sent out to the hospital for symptoms of a stroke. FM #14 responded, .No, When I walked in that room, he started crying .He was in so much pain .I asked them then, are y'all going to send him out for Xrays .The nurse said he doesn't have any broken bones .That's when I demanded [Resident #319] to be sent to the ER .He had not had another stroke, he had a broken hip .I talked to his roommate and [Resident #47] was in his right mind .[Resident #47] said [Resident #319] hit the floor .they [SNF #1] said he never hit the floor . During a telephone interview on [DATE] at 4:15 PM, Former SSD #1 stated, .I asked [Resident #319] to demonstrate how the CNA lowered him to the floor .I backed up to the bed and [Resident #319] extended his arms and reached under my arms like he was catching me . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 12:45 PM, Former DON #1 stated the Interdisciplinary Team (IDT) investigated Resident #319's fall on [DATE] and determined the air mattress on his bed had contributed to him sliding off the bed due to him moving around and an air mattress being slick. Former DON #1 stated residents on an air mattress should have a care plan with interventions in place. When asked what type of interventions would need to be implemented. Former DON #1 replied, .check placement and functioning, and do not use fitted sheets . When asked what is meant by placement and functioning of an air mattress, Former DON #1 replied, Placement is making sure the resident actually has the air mattress, the resident could have moved rooms and the mattress did not follow .Functioning means is the air mattress turned on, is it inflated. When asked if sheets should be used on an air mattress. Former DON #1 replied, No, fitted sheets would prevent the mattress from properly inflating and could possibly turn off the CPR [Cardiopulmonary Resuscitation] function [This function allows for an instant deflation providing a hard surface needed for chest compressions and intubation]. Former DON #1 stated she could not think of any safety interventions that would need to be implemented for use of an air mattress. Former DON #1 was asked if Resident #319 had seizure precautions in place. Former DON #1 stated she was not aware of Resident #319 having a diagnosis for seizures. Former DON #1 stated she would expect his care plan to reflect a diagnosis for seizures with interventions implemented. During an interview on [DATE] at 10:40 AM, the MDS Coordinator was asked to review Resident #319's quarterly assessment dated [DATE]. The MDS Coordinator was asked how she determined Resident #319 required extensive assistance of 2 persons for bed mobility, total dependence for toileting one person assist, and extensive assist of 2 persons for personal hygiene. The MDS Coordinator stated, .I would review the staffing documentation and make visual observations. If I code a resident as total assistance, then the CNA documentation must say the resident required total assistance all the time during the 7 day look back period . The MDS Coordinator was asked how Resident #319 could require 2 person assist for personal hygiene and only require 1 person assist for toileting. The MDS Coordinator stated, .I am not the CNA that cared for him so I can't tell you that . The MDS Coordinator was asked if the CNA documentation was always correct. The MDS Coordinator stated, No. During an interview on [DATE] at 2:50 PM, The MDS Coordinator was asked if seizures were checked on Resident #319's Care Area Assessment (CAA) and Resident #319 was on seizure medication twice a day, should Resident #319 have been care planned for seizures. The MDS Coordinator responded, .Seizures should have been care planned since he was on seizure medication . The MDS Coordinator was then asked if a resident was on an air mattress, should safety measures be care planned. The MDS Coordinator stated, . I don't usually put safety measures in for an air mattress . During an interview on [DATE] at 12:13 PM, Nurse Practitioner (NP) #3 stated she had no record that she or any other of the NP's at the facility had assessed Resident #319 after the fall on [DATE]. The facility's failure to provide a safe environment during care resulted in actual harm when Resident #319 fell from bed and sustained a left hip fracture on [DATE] while receiving incontinence care with use of 1 person assist.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, observation, and interview, the facility failed to provide effective pain management for 2 (Resident #221 and #224) of 5 residents reviewed for pain. The facility's failure to implement an effective pain management program for Resident #221 and Resident #224 resulted in an increase in pain and actual HARM to Resident #221 and Resident #224. The findings include: Review of the facility policy titled, Pain Assessment and Management, dated 5/19/2023 revealed, .The purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain .1. Observe the resident [during rest and movement] for physiologic .signs of pain. 2. Possible Behavioral Signs of Pain .a. negative verbalizations and vocalizations such as groaning .b. facial expressions such as grimacing, frowning .4. Ask the resident if he/she is experiencing pain .Identifying the Causes of Pain .1. Residents may experience pain from several different causes simultaneously. 2. In addition, common procedures such as moving the resident, physical therapies .3. Review the resident's clinical record to identify conditions or situations that may predispose the resident to pain, including .fractures .end of life/hospice care .Establish a treatment regimen that is specific to the resident based on consideration of the following: a. The resident's medical condition .b. Current medication regimen .f. treatment goals . Administering medications around the clock rather than PRN [as needed] . Review of the medical record revealed Resident #221 was admitted to the facility on [DATE] with diagnoses which included Unspecified Trochanteric Fracture of Left Femur, and Type 2 Diabetes Mellitus. Review of baseline care plan dated 1/26/2024 for Resident #221 revealed, .The resident has greater trochanter left femur fracture r/t [related/to] fall .Goal The resident will remain free of complications related to hip fracture, such as contracture formation .Interventions/Tasks .Anticipate and meet needs .Follow MD [Medical Doctor] orders for weight bearing status. See MD and/or PT [Physical Therapy] treatment plan . impaired mobility, Unrelieved pain .PT/OT [Occupational Therapy] evaluation and treatment per orders . Focus At risk for pain related to Acute Illness, Recent Change in Condition-Requiring Skilled Nursing Home Placement, Recent hospitalization .Goal The resident will verbalize adequate relief of pain or ability to cope with incompletely relieved pain .Interventions/Tasks .Monitor/record/report to Nurse any s/sx (signs/symptoms) of non-verbal pain .Vocalizations (grunting, moans, yelling out . Review of the Medication Administration (Admin) Audit Report dated January 2024 for Resident #221 revealed an order for Oxycodone Hydrochloride (HCL) (opioid medication used medically for treatment of moderate to severe pain) Oral Tablet 5 milligram (mg) give 5 mg by mouth four times a day for Chronic Pain and Acetaminophen 500 mg give 1 tablet by mouth three times a day for pain with a scheduled time for 1/30/2024 at 9:00 AM. Further review of the Medication Admin Audit Report revealed on 1/30/2024 Oxycodone HCL 5 mg tablet and Acetaminophen 500 mg tablet was administered at 11:34 AM by Licensed Practical Nurse (LPN) #44. The audit report revealed Resident #221's pain medications were administered 1 hour and 34 minutes late. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	During an observation on the 200 hall on 1/30/2023 at 11:00 AM, Resident #221 was observed walking with his walker with assistance of OT #2 back to his room. Resident #221 requested his pain medication in the hall. OT #2 assisted Resident #221 to the side of his bed to sit down. Resident #221 with a facial grimace, groaned loudly when he sat down on the side of his bed. During an interview on 1/30/2024 at 11:10 AM, OT #2 was asked if Resident #221 received his pain medication prior to his therapy this morning. OT #2 stated, No. OT #2 was asked if Resident #221 was able to complete his therapy session. OT #2 stated, .he was unable to complete all the transfer training. He did complain of pain during his therapy session . During an interview on 1/30/2024 at 11:15 AM with Licensed Practical Nurse (LPN) #44, she was asked why Resident #221 was unable to receive his pain medication prior to his therapy. LPN #44 stated, .this is my first day to be at the facility .I work for agency .I was unable to sign on to the computer to be able to start my medications this morning . LPN #44 stated, .basically all my medications were late this morning . LPN #44 was asked if any manager or other nurse stepped in to help her with the medication pass. LPN #44 stated, No. During an interview on 1/30/2024 at 1:00 PM, Resident #221 was asked about his care at the facility. Resident #221 stated, .my pain meds are late didn't get them this morning and its due again at 1:00 PM . I need my pain medication . The facility failed to provide agency staff with login information to the electronic medical record in a timely manner, therefore pain medication was not administered as ordered, which resulted in actual harm for Resident #221. Review of the medical record revealed Resident #224 was admitted to the facility on [DATE] with diagnoses which included Unspecified Cord Compression, Collapse Vertebra subsequent encounter for Fracture, Malignant Neoplasm of Unspecified Bronchus or Lung, Encounter for Palliative Care, Malignant Neoplasm of Spinal Cord, and Neoplasm related Pain (acute) (chronic). Review of the Admission MDS dated [DATE] for Resident #224 revealed a BIMS score of 14, which indicated no cognitive impairment. Continued review of the MDS revealed Resident #224 received scheduled pain medication and PRN pain medication over the last 5 days. Further review of the MDS revealed a pain assessment interview with a pain frequency of almost constantly. Review of the comprehensive care plan dated 1/12/2024 for Resident #224 revealed, .Focus Resident is at risk for neoplastic disorders Cancer of Lung and spinal cord .Interventions/Tasks .Monitor pain levels and administration pain meds .per MD [Medical Doctor] order .Focus At risk for pain related to .Chronic Illness . Interventions/Tasks .Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Review of the Medication Admin Audit Report for Resident #224 revealed an order for Morphine Sulfate (opioid pain reliever) ER (extended release) 30 mg (milligram) give 1 tablet by mouth every 12 hours for pain with a scheduled time for 1/30/2024 at 8:00 AM. Continued review of the Medication Admin Audit Report revealed an order for Methocarbamol (muscle relaxant) 500 mg give 1.5 tablet by mouth four times a day for muscle spasm with a scheduled time for 1/30/2024 at 9:00 AM. Further review of the Medication Admin Audit Report revealed on 1/30/2024 Morphine Sulfate ER was administered at 13:05 PM by LPN #44 and Methocarbamol was administered at 13:06 PM. The audit report revealed Resident #224's pain medication was administered 4 hours and 5 minutes late and muscle relaxer was administered 3 hours and 6 minutes late. During an observation on the 200 halls on 1/30/2024 at 11:25 AM, Resident #224's call light was on. A housekeeper answered the call light and came out in the hall and told the Unit Manager (LPN #2) Resident #224 wanted her pain medication. During an observation on the 200 halls on 1/30/2024 at 11:30 PM, the Unit Manager (LPN #2) walked by this surveyor smiled and stated, The nurse is behind on her medications, but she is trying to get caught up. During an interview on 1/30/2024 at 12:00 PM, Resident #224 was asked why she had her call light turned on. Resident #224 stated, .My morning pain medication was late .I have Cancer I need my pain meds . Resident #224 was asked what her pain scale was on a scale from 1-10. Resident #224 stated, .It is a 9 but the medications help when I get them . During an interview on 2/6/2024 at 3:35 PM, Former DON #1 was asked if she received a text on 1/30/2024 that an agency nurse needed assistance with a login to the computer system. Former DON #1 looked at her cell phone and stated, .I received a text on 1/30/2024 at 8:28 AM, from the Unit Manager [LPN #2] saying the nurse needed the sign on stuff. I got the login for the nurse, and it usually is ready after 5 minutes . Former DON #1 was asked if it was normal for an agency nurse not to have her login information prior to her starting her shift. Former DON #1 stated, It would depend on who the on-call person was, if I were on call, I would look at the schedule and see if I needed to get one for a nurse. During an interview on 2/6/2024 at 7:55 AM, LPN #9 was asked if she was an agency nurse for the facility. LPN #9 stated, .I use to be an agency nurse but not now. I wasn't given any training prior to starting as an agency nurse. I had to wait to get a login for the computer system which makes it hard to start your medications . The facility failed to administer pain medications as ordered, which resulted in actual harm for Resident #224.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. Building B. Wing	02/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Hills Center for Rehabilitation and Healing	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)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 44724 Based on facility policy, QAPI (Quality Assurance and Performance Improvement) documentation, and interview, the facility failed to identify and correct quality deficiencies when Resident #106 exited the building in his wheelchair and his absence remained unnoticed for 7.5 hours on 12/8/2023. The facility also failed to identify and correct quality deficiencies when Resident #319 fell from bed during care and sustained a left hip fracture on 5/26/2022. The findings include: 1. Review of the facility policy titled, QAPI (Quality Assurance and Performance Improvement) Program, dated 10/20/2022 revealed, .This facility shall develop, implement, and maintain an ongoing, facility-wide, data-driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents .The objectives of the QAPI program are to .1. provide a means to measure current and potential indicators for outcomes or care and quality of life .2. provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators .3. reinforce and build upon effective systems and processes related to the delivery of quality care and services . Implementation .2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include .identifying and prioritizing quality deficiencies .systematically analyzing underlying causes of systemic quality deficiencies .developing and implementing corrective action or performance improvement activities .monitoring and evaluating the effectiveness of corrective action/performance improvement activities, and revising as needed . The facility failed to provide an environment that remained free of accident hazards and adequately supervise Resident #106 when he exited the facility unnoticed on 12/8/2023. Refer to F689. During an interview on 12/20/2023 at 1:58 PM, the Administrator was asked when an incident or accident occurs what actions does the facility take. 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 . During a telephone interview on 12/20/2023 at 3:11 PM, the Medical Director (MD) was asked if he was involved in a emergency Quality Assurance Performance Improvement (QAPI) meeting related to Resident #106 leaving the building unnoticed, he replied, .I am [now] looking at [Named electronic computer charting system] .I wasn't involved with a root cause analysis . _____ (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445267	A. Building B. Wing	02/06/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the QAPI Meeting/Four Point Plan of Correction Agenda and Summary notes dated 6/2022 revealed, no documentation noted for a fall with a fracture for 5/2022. During an interview on 1/30/2024 at 3:38 PM, the Administrator did not have an explaination for why the left hip fracture was not documented on the June QAPI notes. The facility failed to prevent an avoidable accident which resulted in a major injury when Resident #319 had a fall from bed during incontinence care and sustained a left hip fracture. Refer to F689 46831