

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Green Hills Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 Hillsboro Circle Nashville, TN 37215	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on review of the Resident Rights document, medical record review, observation, and interview, the facility failed to treat residents with respect and dignity when 4 of 15 (Certified Nursing Assistant (CNA) K, L, M, N) and (Minimum Data set (MDS Nurse) staff members stood over a residents (Resident #12, #33, #45, #54, and #90) to assist with the meal.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's Resident Rights, document dated February 2021, revealed .Employees shall treat all residents with kindness, respect, and dignity . 2. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Cerebral Infarction, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure. <p>Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severe cognitive impairment. Resident #12 required assistance from staff for eating, bathing, grooming, and dressing.</p> <p>Observation on 1/28/2025 at 7:45 AM, revealed CNA K stood over Resident #12 to assist her with the meal.</p> <ol style="list-style-type: none"> 3. Review of the medical record revealed Resident #33 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Insomnia, Anxiety, and Pain. <p>Review of the annual MDS assessment dated [DATE], revealed a BIMS score of 00, which indicated Resident #33 had severe cognitive impairment. Resident #33 required assistance from staff for activities of daily living (ADLs).</p> <p>Observation on 1/28/2025 at 8:01 AM, revealed CNA M stood over Resident #33 to assist her with the meal.</p> <ol style="list-style-type: none"> 4. Review of the medical record revealed Resident #45 was admitted to the facility on [DATE] with diagnoses including Dysphagia, Adult Failure to Thrive, Cerebrovascular Disease, and Bell's Palsy. <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #45 was cognitively intact.</p> <p>Observation on 1/28/2025 at 8:01 AM, revealed CNA L stood over Resident #45 to assist her with the meal.</p> <p>5. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE], with diagnoses including Diabetes, Contractures, Chronic Obstructive Pulmonary Disease, and Anxiety.</p> <p>Review of the annual MDS assessment dated [DATE] revealed Resident #54 had a BIMS score of 15. Resident #54 was dependent on staff for eating, bathing, grooming.</p> <p>Observation on 1/27/2025 at 12:27 PM and on 1/28/2025 at 7:57 AM, revealed CNA K stood over Resident #54 to assist him with the meal.</p> <p>Observation on 1/31/2025 at 8:29 AM, revealed MDS Nurse stood over Resident #54 to assist him with the meal.</p> <p>6. Review of the medical record revealed Resident #90 was admitted to the facility on [DATE], with diagnoses including End Stage Renal Disease, Diabetes, Lymphedema, Glaucoma, Heart Failure, and Anxiety.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 15, which indicated Resident #90 was cognitively intact. Resident was dependent on staff for eating, toileting, bathing, transfers.</p> <p>Observation on 1/28/2025 at 8:15 AM, revealed CNA N stood over Resident #90 to assist him with the meal.</p> <p>7. During an interview on 2/3/2025 at 8:55 PM, the Director of Nursing (DON) was asked should staff stand over a resident to assist with their meal. The DON stated, No, should sit at bedside. Should not stand over them.</p> <p>49269</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>38439</p> <p>Based on policy review, observation, and interview, the facility failed to maintain privacy and confidentiality of residents' medical record for 27 of 119 (Resident #4, #10, #11, #19, #23, #27, #29, #31, #33, #36, #41, #47, #50, #51, #52, #53, #60, #75, #77, #81, #82, #88, #94, #98, #106, #107, and #110) sampled residents observed during a random observation and medication administration.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Resident Rights, dated 2/2011, revealed .Employees shall treat all resident 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 .privacy and confidentiality . Observation on the 200 Hall on 1/30/25 at 12:07 PM, revealed Licensed Practical Nurse (LPN R) sitting at the nurses' desk away from the 200 Hall Medication Cart #1. <p>During observation and interview at the 200 Hall Medication Cart #1 on 1/30/2025 at 12:08 PM, revealed the computer screen opened and viewable with the following residents name and room numbers visible: Resident #4, #29, #31, #36, #41, #50, #51, #60, #75, #81, #82, #98, #107, and #110. LPN R was asked should the computer screen be left opened, unattended with residents' information visible and viewable. LPN R stated, No, it should be closed when no one is at the cart .</p> <ol style="list-style-type: none"> Observation on the 300 Hall at Medication Cart #2 on 2/3/2025 at 4:09 PM and 4:11 PM, revealed the computer screen left opened and viewable with the following residents name and room numbers visible: Resident #10, #11, #19, #23, #27, #33, #47, #52, #53, #77, #88, #94, and #106. LPN Q left the computer screen opened and unattended when she entered Resident #94's room and when she entered Resident #53's room leaving the computer screen up and visible with the residents' name and room numbers displayed on the screen. During an interview on 2/3/2025 at 8:55 PM, the Director of Nursing (DON) was asked should the computer screen be left unattended with residents' name and room numbers displayed. The DON stated, No . 		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909</p> <p>Based on policy review, medical record review, and interview, the facility failed to conduct quarterly care conference meetings for 5 of 24 (Resident #9, #10, #25, #36, and #39) sampled residents reviewed.</p> <p>The findings include:</p> <p>1. Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, revealed .Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan or care, including the right to .participate in the planning process .identify individuals or roles to be included .request meetings .request revisions to the plan of care .participate in establishing the expected goals and outcomes of care .participate in determining the type, amount, frequency and duration of care .see the care plan and sign it after significant changes are made .The resident is informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process .</p> <p>2. Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Stroke, Hypertension, Malnutrition, and Asthma.</p> <p>Review of the annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated Resident #9 had mild cognitive impairment.</p> <p>Review of the medical record revealed the facility held a care plan meeting on 6/17/2024. The facility failed to provide documentation of quarterly care plan meetings for Resident #9 since 6/17/2024.</p> <p>3. Review of the medical record revealed Resident #10 was admitted to the facility on [DATE] with diagnoses including Cancer, Hypertension, Anemia, Diabetes, and CVA.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 14, which indicated Resident #10 had no cognitive impairment.</p> <p>Review of the medical record revealed the last care plan meeting was 3/22/2024. The facility failed to provide documentation of quarterly care plan meetings for Resident #10 since 3/22/2024.</p> <p>4. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Polymyositis, Obstructive Sleep Apnea, Neuromuscular Dysfunction of Bladder, and Depression.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the quarterly MDS dated [DATE] revealed a BIMS score of 15, which indicated Resident #25 had no cognitive impairment.</p> <p>Review of the medical record revealed a care plan meeting was held with Resident #25 on 6/3/2024.</p> <p>The facility was unable to provide documentation of the next scheduled care plan meeting for Resident #25 until 2/3/2025.</p> <p>5. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including Chronic Pain, Diabetes, Myelopathy, Chronic Obstructive Pulmonary Disease, and Paraplegia.</p> <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 15, which indicated Resident #36 had no cognitive impairment.</p> <p>Review of the medical record revealed a care plan meeting was held with Resident #36 on 7/11/2024 and the next care plan meeting was not provided until 12/11/2024.</p> <p>The facility failed to provide documentation of quarterly care plan meetings for Resident #36.</p> <p>7. Review of the medical record revealed Resident #39 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Anxiety, and Depression.</p> <p>Review of the significant change MDS dated [DATE], revealed a BIMS score of 14, which indicated Resident #39 was cognitively intact.</p> <p>Review of the Care Conference Notes revealed the facility held a care plan meeting on 4/4/2024 and 6/20/2024.</p> <p>The facility failed to provide documentation of quarterly care plan meetings for Resident #39 since 6/20/2024.</p> <p>8. During an interview on 2/3/2025 at 8:04 PM, the Director of Nursing (DON) confirmed that care plan meetings should be held quarterly.</p> <p>47835</p> <p>49269</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services related to activities of daily living (ADLs) for 3 of 7 (Resident #5, #9, and #317) sampled residents for ADLs.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, revealed . 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 .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with .hygiene (bathing, dressing, grooming, and oral care) . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #21 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment .resident required assistance for all ADLs.</p> <p>Review of the Care Plan dated 5/9/2024, revealed .Resident requires assist with activities of daily living . Assist with bed mobility, transfers, toileting, and bathing as required .</p> <p>Review of the Skin Monitoring: Comprehensive CNA [Certified Nursing Assistant] Shower Review, dated 1/3/2025 revealed the facility failed to complete the sheet except for signature.</p> <p>Review of the facility's Skin Monitoring: Comprehensive CNA Shower Review, for January 2025 revealed Resident #5 did not receive a shower after 1/7/2025.</p> <p>The facility was unable to provide documentation Resident #5 received a shower or bath after 1/7/2025 for the month of January 2025.</p> <ol style="list-style-type: none"> Review of the medical record revealed Resident #9 was admitted to the facility on [DATE], with diagnoses including Stroke, Hypertension, Malnutrition, and Asthma. <p>Review of the annual MDS assessment dated [DATE], revealed BIMS score of 10, which indicated moderate cognitive impairment. Resident #9 required maximal assistance with bathing and showers.</p> <p>Review of the facility Podiatry Referrals form for the 300 Hall revealed 8-18 [2024] .[Named Resident #9]</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician's Order dated 1/11/2023, revealed May receive services from .Podiatrist .and other specialist(s) as necessary.</p> <p>Review of the Nurses Note dated 8/18/2024, revealed [Named Daughter] stated, .give him a shower, and cut his toenails .</p> <p>Observation in Resident #9's on 1/28/2025 at 1:41 PM, revealed CNA II removed Resident #9's socks to assess his feet. The toenails were long, thick, and unkempt.</p> <p>During an observation and interview on 1/31/2025 at 11:50 AM, Unit Manager 3rd was shown Resident #9's fingernails and toenails and confirmed the resident needed to be seen by podiatry.</p> <p>4. Review of the medical record revealed Resident #317 was admitted to the facility on [DATE], with diagnoses including Cerebral Vascular Accident, Dysphagia, and Percutaneous Endoscopy Gastrostomy.</p> <p>Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 4, which indicated Resident #317 had severe cognitive impairment, and was dependent upon staff for ADLs.</p> <p>Review of the Care Plan dated 1/17/2025, revealed Resident #317 was dependent upon staff for showers and grooming.</p> <p>Review of the Master Shower Schedule sheet revealed Resident #317 was scheduled for showers on Tuesdays and Fridays.</p> <p>Review of the facility's electronic Shower Sheet revealed Resident #317 had not received a shower since 1/17/2025.</p> <p>Observations in Resident #317's room on 1/28/2025 at 8:30 AM and 2:40 PM, on 1/30/2025 at 8:02 AM and 5:05 PM, on 1/31/2025 at 7:51 AM and 1/31/2025 at 1:06 PM, and on 2/3/2025 at 10:35 AM, revealed Resident #317's hair was unkept and uncombed.</p> <p>During an interview on 2/3/2025 at 10:44 AM, Licensed Practical Nurse (LPN U) confirmed residents should get a shower two times per week, and CNAs should complete shower sheets. LPN U confirmed Resident #317 had not had a shower since 1/17/2025 and the resident should have received showers as scheduled.</p> <p>During an interview on 2/3/2025 at 7:13 PM, LPN T confirmed Resident #317's hair was not groomed and combed.</p> <p>During an interview on 2/3/2025 at 7:20 PM, LPN U confirmed all residents should be groomed with hair combed daily.</p> <p>During an interview on 2/3/2025 at 9:17 PM, the Director of Nursing (DON) confirmed female residents' hair should be combed (groomed) daily.</p> <p>46047</p> <p>49269</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38909</p> <p>Based on policy review, medical record, observation, and interview, the facility failed to provide care and services for the prevention of pressure ulcer/injury for 1 of 4 (Resident #61) sampled residents reviewed for pressure ulcer/injuries.</p> <p>The findings included:</p> <p>1. Review of the facility's policy titled, Pressure Injuries Overview, dated 1/28/2025, revealed .Pressure Ulcer/Injury (PU/PI) refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence .A pressure injury will present as intact skin and may be painful .A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful .Pressure ulcers/injuries occur as a result of intense and prolonged pressure .The tolerance of soft tissue for pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities and condition of the soft tissue .Tissue tolerance is the ability of the skin and its supporting structures to endure the effects of pressure, without adverse effects. Tissue tolerance affects the length of time a resident can maintain a position without suffering a pressure ulcer/injury .Stage 4 Pressure Injury: Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer . Slough and/or eschar may be visible .Depth varies by anatomical location .If slough or eschar obscures the extent of tissue loss, this is an Unstageable PI .Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon discoloration or epidermal separation reveals a dark wound bed or blood-filled blister .This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface .</p> <p>Review of the facility's policy titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, dated 11/30/2022, revealed .The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s) . the nurse shall describe and document/report the following .Full assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue .Pain assessment . Resident's mobility status .Current treatments, including support surfaces .and all active diagnoses .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Pressure Ulcer Risk Assessment, dated 9/2013, revealed .The purpose of this procedure is to provide guidelines for the assessment and identification of residents at risk of developing pressure ulcers .Review the resident's care plan to assess for any special needs of the resident . Review current Braden Scale or facility risk assessment tool .Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area, which destroys the tissue .If pressure ulcers are not treated when discovered, they have the potential to become larger, painful and infected .Pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin .perspiration, wound discharge .Encourage the resident to participate in active and passive range of motion exercises to improve circulation .Routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. Immediately report any signs of a developing pressure ulcer to the supervisor .Skin Assessment .skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated .Staff will perform routine skin inspections (with daily care) .Nurses are notified to inspect the skin if skin changes are identified .Nurses will conduct skin assessments at least weekly to identify changes .Extrinsic risk factors for pressure ulcers include .pressure .the resident is not capable of moving without assistance, is confined to bed, and/or requires a regular schedule of turning .Steps in the procedure .Once inspection of skin is completed proceed to the Weekly Skin Integrity tool and complete documentation of findings .If a new skin alteration is noted, initiate a (pressure or non-pressure) form related to the type of alteration in skin .Proceed to care planning and interventions individualized for the resident and their risk factors .The following information should be recorded in the resident's medical record utilizing facility forms: The type of assessment conducted .(. Weekly Skin Integrity tool) The date and time and type of skin care provided .The name and title(or initials) of the individual who conducted the assessment .The condition of the resident's skin (.the size and location of any red or tender areas) .If resident refused the treatment, the reason for refusal the procedure, the benefits of accepting and available alternatives. Document family and physician notification of refusal . Initiation of a (pressure or non-pressure) form related to the type of alteration in skin if new skin alteration noted .Documentation in medical record addressing MD notification if new skin alteration noted with a change of care plan .Documentation in medical record addressing family, guardian or resident notification if new skin alteration noted with change of plan of care .</p> <p>2. Review of the medical record revealed Resident #61 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Hemiplegia and Hemiparesis, Chronic Pain, and Muscle Weakness.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #61's Care Plan dated 11/15/2024, revealed .Resident requires assist with activities of daily living .Has left sided neglect [a neurological condition where a person fails to notice, attend to or respond to stimuli on their left side] please be aware .skin inspection .monitor for redness, open areas . immediately report changes to the nurse .Resident prefers two showers per week .At risk for pressure injury development .Resident will be free of pressure injury development .Administer treatments as ordered and monitor for effectiveness .Educate the resident/family/caregivers as to causes of skin breakdown; including transfer/positioning requirements; importance of taking care during .mobility .and frequent repositioning . Notify nurse immediately of any new areas of skin breakdown .Redness, Blisters, Bruises, discoloration noted during bath or daily care .Remind/assist resident to frequently change position when in bed and/or chair .The resident is resistive to care r/t [related to] Refusing Showers .Allow the resident to make decisions about treatment regime, to provide sense of control .If resident resists with ADL's [activities of daily living skills], reassure resident, leave and return 5-10 minutes later and try again .Provide resident with opportunities for choice during care provision .The resident has Hemiplegia/Hemiparesis r/t history of CVA [cardiovascular accident] .The resident will remain free of complications or discomfort related to Hemiplegia/Hemiparesis through review date .The resident will maintain optimal status and quality of life within limitations imposed by Hemiplegia/Hemiparesis through review date .Range of motion (active or passive) with am/pm care daily .Assist with ADLs/Mobility as needed .</p> <p>Review of Resident #61's Braden Scale dated 11/23/2024, revealed .Score: 12 .Category: High Risk . SENSORY PERCEPTION .Slightly Limited: Responds to verbal commands, but cannot always communicate discomfort or need to be turned .has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities .MOISTURE .Very Moist: Skin is often, but not always moist. Linen must be changed at least once a shift .ACTIVITY .Bedfast: confined to bed .MOBILITY .Very limited: Makes occasional slight changes in body or extremity position but unable to make frequent of significant changes independently .</p> <p>Review of Resident's #61's quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #61's had a Brief Interview for Mental Status score of 13, indicating intact cognition and functional ability was coded as dependent for all activities of living.</p> <p>Review of facility's Nosocomial Pressure Ulcer form dated 1/20/2025, for Resident #61 revealed .a suspected DTI [Deep Tissue Injury] to front of left ear .Staff stated resident lays primarily on left side . Resident has decreased bed mobility . This document was presented to state surveyors via email after exit date from facility. The bottom of the document stated, Not part of the Medical Record.</p> <p>The facility failed to provide this documentation when surveyors were in the building from 1/27/2025 to 2/3/2025.</p> <p>Review of Resident #61's medical record did not show documentation of the DTI to the left ear on 1/20/2025. No Physician's Order for treatment to the DTI, no documentation of the appearance or size of the pressure injury, and no documentation for a treatment to the DTI to the left ear on the facility's treatment administration record (TAR).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Green Hills Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 Hillsboro Circle Nashville, TN 37215	
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's Skin and Wound Evaluation sheet dated 1/21/2025, revealed .Type .Pressure .stage 4: Full -thickness skin and tissue loss .In-House Acquired .wound present .exact date 1/21/2025 .Wound measurements .Length 1.5 cm[centimeters] .Width 1.0 cm .depth not applicable .Wound bed Granulation 40% [percent] of wound bed .Exudate .Light .serous .Surrounding tissue .Erythema: redness of skin .</p> <p>Review of the Physician's Order dated 1/21/2025, revealed .Pressure stage 4 front left ear .cleanse with NS [normal saline] apply Medi honey [medication used to debride pressure ulcers from stage 1 to stage 4] cover with dry dressing M [Monday] W [Wednesday] F [Friday] and as needed .</p> <p>Review of Resident #61's TAR for January 2025, revealed the TAR was signed out on 1/22/2025. No documentation the treatment was performed until 1/22/2025.</p> <p>Review of the facility's Skin and Wound Evaluation sheet dated 1/24/2025, revealed .Type .Pressure .Stage 4 .In-House Acquired .Exact date 1/21/2025 .Wound Measurements .Length 1.5 cm .Width 0.8 cm .Depth 0.3 cm .Wound bed Granulation 20%of wound filled .slough 40% of wound filled .Exudate none .Surrounding tissue .Normal in color .</p> <p>Observation in Resident #61's room on 1/27/2025 at 11:41 AM, revealed Resident #61 lying in bed on his back with his head turned to the left side and no wound dressing to his left ear pressure ulcer/injury.</p> <p>Observation in Resident #61's room on 1/28/2025 at 9:11 AM, revealed Resident #61 was laying on his left side with no dressing to his left ear pressure ulcer/injury.</p> <p>Review of Resident #61's medical record revealed nutritional interventions were not put in place and started until 1/28/2025, 1/29/2025 and 1/31/2025.</p> <p>Observation in Resident #61's room on 1/30/2025 at 10:10 AM, revealed Resident #61 in bed laying on his left side, stage 4 pressure injury to left ear appears red with open area with serosanguinous drainage, and no intact wound dressing.</p> <p>Review of the facility's INTEGRATED WOUND CARE Follow-up Progress Note dated 1/31/2025, revealed . [Named] Resident [#61] confused and combative .he has weakness and has contracted left elbow .He is unable to turn his head toward the right .has purulent drainage to left ear canal .HOH [hard of hearing] . delayed wound healing .placed on air mattress today .Wound: Pressure ulcer Front Ear left Stage 4 . L [length] x [by] W [width] x D [depth] cm [centimeter] 1.5cm x 0.4 cm x 0.2 cm .EXUDATE: Light Serous . Treatment Recommendations: Medi honey, cover with gauze and Tegaderm .Q [every] D [day]and PRN [as needed] .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/31/2025 at 9:44 AM, the Director of Nursing (DON) was asked when Resident #61's pressure injury stage 4 was observed. DON stated, It was observed on 1/21/2025. The DON was asked if pressure injuries should start at a stage 4. The DON stated, No, not typically, but he tends to lay his head to the left side. The DON was asked what caused the development of the pressure injury to Resident #61's left ear. The DON stated, I feel the pressure injury was caused by his head laying to the left side .I'm sure that didn't help the ear area that he lays on. The DON was asked if a wound dressing should be intact on the ear. The DON stated, Yes. The DON was asked if nutritional interventions were started on 1/21/2025.The DON stated, No, but the Nurse Practitioner will do that today . The DON was asked should the resident have had interventions put into place as soon as the wound was identified. The DON stated, Yes.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47835</p> <p>Based on policy review, medical record review, and interview, the facility failed to ensure a safe and secure environment for 1 of 1 (Residents #25) residents reviewed for accident hazards.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the facility's undated form titled .AGAINST MEDICAL ADVICE-ACKNOWLEDGEMENT AND WAIVER . revealed .The above named physician has recommended a specific course of therapy, method of treatment or a means diagnosing and/or treating a medical condition for the patient named .is a medical decision that is made by the physician based upon the findings of an examination and/or diagnostic testing . The physician believes this recommendation is in the patient's best interest .The specific recommendation(s) being made by the physician includes the following [blank lines to include the physician's recommendations] . The patient has elected not to follow the recommendations of the physician as noted above and accepts responsibility for any consequences of that decision .The risks of not following the physician's recommendations have been fully explained to the resident by the physician .The patient agrees that the physician shall not be held responsible or legally liable for the decision or any future consequences of the patient's decision .By signing .the patient acknowledges that s/he has read this information and has elected not to follow the physician's recommendations . 2. Review of the facility policy titled, SUBSTANCE USE DISORDER, dated 11/2022 revealed, .Residents who are admitted to the facility with substance use disorder (SUD) will receive the necessary behavioral health care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being, provided by the facility and in accordance with the comprehensive assessment and care plan . SUD is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment .The resident's history of substance use disorder and risk for using substances which could lead to an overdose while in the facility are identified to the extent possible and documented in the medical record .In addition, safety and health concerns specific to the resident and his or her history are identified .Health and safety considerations related to substance use disorder may include .increased risk of falls and other accidents .potential for wandering and elopement .potential for resident-to-resident altercations and other disruptive behaviors .potential for .mood disorders .Care plan interventions are directed at maintaining the safety of the resident, staff and other residents .examples of appropriate care interventions .include . monitoring the resident for .changes in behavior .slurred speech .lack of coordination .especially after returning from a leave of absence .increasing supervision of the resident .Behavioral contracts may be initiated to address behaviors .used .with residents who have the capacity to understand them communicates the resident's rights to have a leave of absence and also explains the health and safety risks of leaving without facility knowledge or leaving against medical advice (AMA) .if substance abuse is suspected, a behavioral contract may stipulate .monitoring and supervision .may be increased .voluntary inspections may be conducted if there is reasonable suspicion of .unauthorized items .local law enforcement will be notified if there is suspicion .of illegal substances .Non-adherence to the contract will be treated as a care plan intervention that needs attention or needs to be altered to meet the needs of the resident .The IDT [Interdisciplinary Team] will work with the resident .to revise the care plan and contract . <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record revealed Resident #25 was admitted to the facility on [DATE], with diagnoses including Polymyositis, Neuromuscular Dysfunction of Bladder, and Depression.</p> <p>Review of the admission Minimum Data Set (MDS) dated [DATE], and the quarterly MDS dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had no cognitive impairment, required maximum assistance with transfers, and the use of a motorized electric wheelchair.</p> <p>Review of a Progress Note dated 6/8/2024, revealed . resident yelling out help call 911 .consumed delta 8 [tetrahydrocannabinol-THC-the main psychoactive substance found in the Cannabis plant] gummies bought outside of facility. took gummies and locked in cart. Np [nurse practitioner] advised to check vitals q [every]15 (minutes) for hr [hour] .resident back in bed, will continue to monitor .</p> <p>The facility was unable to provide documentation that Resident #25 was monitored and assessed for the effects of the consumption of a Cannabis gummy every 15 minutes for an hour as ordered by the nurse practitioner.</p> <p>Review of the Care Plan dated 6/21/2024 revealed .Substance Abuse Disorder (history of polysubstance abuse .Resident has dx [diagnosis] of history substance abuse disorder cocaine and ETOH [alcohol] with potential for negative outcome .Resident is at risk for substance use/abuse, self medications, including over medicating, drug seeking behaviors .Delta 8 Gummy (candy with marijuana) Use .observe for s/s [signs and symptoms] for sue [SUD] or self medicating including over use (drowsiness, changes in mental status, behavior changes, notify provider of acute changes .)</p> <p>Review of the Encounter Note dated 7/8/2024, revealed .resident has left facility on multiple occasions and returned intoxicated from alcohol [from alcohol] or delta 8 .Reports that she goes to a Mexican restaurant every Friday and has a few margaritas .</p> <p>Review of the Nursing Progress Note dated 7/31/2024, revealed .Resident .asked if therapy could take her off campus via [by way of] the driveway .facility staff could not because there is no safe egress to the street from center property .</p> <p>Review of the Nursing Progress Note dated 8/4/2024, revealed .Followed resident off property due to safety concerns, ignoring traffic signals and riding down the middle of the driveway.</p> <p>The facility was unable to provide documentation what time Resident #25 returned back to the facility after leaving AMA, and documentation of the education given on the importance of following traffic signals and the risk of riding in the middle of the driveway.</p> <p>Review of the Nursing Progress Note dated 8/4/2024, revealed .signed out on LOA, returned to facility with (3) 375 ml [milliliters] of Vodka [clear alcoholic beverage] .Resident stated she was going to go hide them on property so she can take it with her on Wed [Wednesday] for LOA .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Encounter Note dated 8/5/2024 revealed .The facility has one entrance, which is a sloped driveway directly connected to a main street. Staff reports that resident will ride her motorized wheelchair down the driveway, which poses a concern for entering the street. While out recently, resident purchased 3 bottles of liquor and brought them back to the facility. When facility staff stopped her, resident reported that she brought them to drink when she takes a leave of absence in the next few days .</p> <p>Review of the Nurse Practitioner Note on 8/5/2024, revealed .The patient was observed exiting the property via her motorized wheelchair, navigating the car entrance and exit ramp and heading towards a busy street on 8/4/24. This behavior was deemed unsafe and against facility protocols previously .Additionally, nursing staff confirms her purchasing three pints of [NAME] Vodka during her outing and bringing them back [them back] into the facility, which raises safety concerns regarding alcohol use in conjunction with operating her motorized wheelchair . Alcohol use .</p> <p>Review of the Care Plan updated and revised on 8/5/2024 revealed .Resident fails to comply with LOA [Leave of Absence] policy, despite education .Encourage resident to be safe while in the community on LOA (.utilize cross walks, no panhandling, no drugs or ETOH use .) .Explain possible adverse reaction related to unsafe behavior while in community .</p> <p>Review of the Nurse Practitioner Note on 8/12/2024, revealed .found outside expressing extreme distress and confusion .behavior has been erratic .today .was found in possession of alcohol, directly contravening facility rules .safety concerns after a discussion with a police officer .gave .bottle of Fireball to the police officer .The patient has violated the facility's alcohol policies at least twice, including an instance today when she was found with a bottle of Fireball .</p> <p>Review of the Encounter Note dated 8/26/2024 revealed .Staff reports that on 8/12 [2024], resident was found outside of the facility inebriated and with alcohol on her person .proceeded to make accusatory and paranoid statements, saying .staff was holding her hostage .would not let her leave .police were called and the alcohol .was confiscated. Resident [#25] was returned to her room and placed on every 15-minute rounds for safety and behavioral management .extensive history of leaving the facility to obtain alcohol and illicit substances .has been told it is unsafe .to leave the facility independently .due to her physical limitations and usage of a motorized wheelchair .</p> <p>The facility was unable to provide documentation of the 15 minute checks for Resident #25 after leaving the facility AMA and returning with alcoholic beverages and being inebriated.</p> <p>Review of the facility's Against Medical Advice forms, revealed the facility failed to ensure the completion of the AMA forms for 11/11/2024, 11/12/2024, 11/16/2024, 11/17/2024, 11/18/2024, 11/23/2024, 11/25/2024, 11/27/2024, 12/7/2024, 12/11/2024,12/13/2024, 12/15/2024, 12/17/2024, 12/23/2024, 12/26/2024, 12/27/2024, 12/30/2024, 12/31/2024, 1/1/2025, 1/4/2025, 1/8/2025, 1/11/2025, 1/12/2025, 1/13/2025, 1/14/2025, 1/15/2025, 1/17/2025, 1/19/2025, 1/23/2025, 1/25/2025, 1/28/2025, 1/29/2025, 2/1/2025, and 2/3/2025, to include what education was given to Resident #25 when she signed the AMA form to leave the facility on LOA. There was no documentation of the times when Resident #25 left the facility AMA and when she returned to the facility, and no documentation of a Resident assessment and monitoring done upon return to the facility.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 1/28/2025 at 2:15 PM, Resident #25 stated they say cars come in too fast .I like to go get a drink every once in a while, will go to [restaurant] or liquor store .I've downed my drinking to just fairly tipsy then just coming back and watch a movie .</p> <p>During an interview on 1/30/25 at 11:52 AM, the Administrator presented a form called Against Medical Advice-Acknowledgment and Waiver and stated, .This is for the ones who want to leave and go do their thing because they have a BIMS of 15 .who want to go out and drink or that goes out in the dead of winter .they have to sign that before they can go out .</p> <p>During an interview on 2/3/2025 at 10:17 AM, the Administrator stated .If she [Resident #25] is belligerent or yelling out we will assume she has been drinking .We had to ask one of her friends one time to meet her in the lobby to visit because she was seen bringing stuff [alcohol] in for her .</p> <p>During an interview on 2/03/2025 at 10:48 AM, Receptionist FF stated .We will ask her where she is going, sometimes she will tell us, sometimes not .If she won't tell us where she's going, we will make her sign the AMA paper . Sometimes she will say she is going just out there to sit but will go somewhere else .If I notice she is gone, I will let the administrator know. She [Resident #25] goes out multiple times throughout the day .</p> <p>During an interview on 2/3/2025 at 11:36 AM, LPN EE stated .she is supposed to sign out when she goes out .will call administrator if I suspect she is intoxicated .I will just get her vital signs .Last Friday she had a tech she got mad at, flipped out on her .come to find out she had been out drinking .If I notice she is not on the floor for a couple hours or something I will usually call down to the front desk to see if she has checked out or something .but no she doesn't come tell me if she is going out or not .</p> <p>During an interview on 2/3/25 at 12:05 PM, the Administrator stated .The only thing that she signs out on is the AMA and LOA forms .AMA when she is going outside or somewhere on her own, the LOA when she is leaving with family or to the doctor. No, she doesn't put the times down .we just have the date she is leaving and the date she is coming back .If we look outside and she is gone they will call me .I text her or call her . she's usually within a block of this place .unless she takes the bus and goes somewhere else. If she comes back and we think she is intoxicated, I will call the police. I did call them one time but by the time they got here she was already in the building. They told me they couldn't do anything if she is in here.</p> <p>During an interview on 2/3/2025 at 9:32 PM, the Administrator was asked what system was in place to ensure the safety of Resident #25 while she is out AMA. The Administrator was unable to say what was put in place other than the AMA form. The Administrator was asked if there was documentation of the education given each time when Resident #25 goes out AMA. The Administrator was unable to provide documentation of the education that Resident #25 was given related to her leaving the facility AMA, traffic and safety issues, and her returning back to the facility intoxicated other than the incomplete AMA forms provided. The Administrator was asked if the AMA sheet was completely filled out if it was missing the responsible Physician, times, and a witness signature. The Administrator stated, . That's just the sheet that we made up to remind her she is going out against medical advice . The Administrator confirmed that the facility was responsible for the safety of Resident #25 and that a plan needed to be in place to ensure the safety of Resident #25 and other residents.</p> <p>49269</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on facility policy review, medical record review, observation, and interview, the facility failed to provide appropriate services and treatment for an indwelling urinary catheter for 1 of 3 (Resident #317) reviewed for the use of a urinary catheter care, when the facility failed to obtain an order, failed to revise the care plan for the use of an indwelling urinary catheter, and when 1 of 1 (Certified Nursing Assistant (CNA) HH) failed to perform hand hygiene during catheter care.</p> <p>The findings include:</p> <p>1. Review of the facility policy titled, Indwelling (Foley) Catheter Insertion, Female Resident dated 5/19/2023, revealed .Verify that there is a physician's order .</p> <p>Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, revealed . Assessments of residents are ongoing and care plans are revised as information about the residents and resident's conditions are changed .reviews and updates the care plan .when there has been a significant change in condition in the residents condition .when the resident has been readmitted to the facility from a hospital stay .</p> <p>Review of the facility's policy titled, Handwashing Hand Hygiene, dated 1/27/2025, revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Hand hygiene is indicated .after contact with blood, body fluids, or contaminated surfaces .before moving from work on a soiled body site to a clean body site on the same resident .immediately after removing gloves .The use of gloves does not replace hand washing/hand hygiene .Applying and Removing Gloves .Perform hand hygiene before applying gloves .</p> <p>2. Review medical record revealed Resident #317 was admitted to the facility on [DATE], with diagnoses including Cerebral Vascular Accident (Stroke), Dysphagia, and Percutaneous Endoscopy Gastrostomy (PEG) tube.</p> <p>Review of the Admission/Readmission Evaluation dated 1/17/2025, revealed, Resident #317 returned to the facility with an indwelling urinary catheter.</p> <p>Review of the admission Minimum Data Set, dated dated dated [DATE], revealed a Brief Interview for Mental Status score of 4, which indicated Resident #317 had severe cognitive impairment.</p> <p>Review of the medical record revealed Resident #317 did not have a physician's order for the use of an indwelling urinary catheter until 1/27/2025 (during the survey).</p> <p>Review of the Care Plan dated 1/17/2025, revealed Resident #317 was not care planned for the use of an indwelling urinary catheter until 1/27/2025 (during the survey).</p> <p>Observations in Resident #317's room on 1/30/2025 at 8:02 AM and 1/31/2025 at 7:51 AM, revealed Resident #317 had an indwelling urinary catheter.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/3/2025 at 10:26 AM, Licensed Practical Nurse (LPN U) confirmed Resident #317 returned to the facility on [DATE], with an indwelling urinary catheter and an order should have been put in for the use when she returned to the facility.</p> <p>Observation on 2/3/2025 at 5:26 PM, revealed CNA HH provided incontinent stool care for Resident #317, removed her gloves, failed to perform hand hygiene before donning another pair of gloves, and proceeded to provide catheter care.</p> <p>During an interview on 2/3/2025 at 8:58 PM, the Director of Nursing (DON) confirmed that the facility must obtain an order for the use of an indwelling urinary catheter and must revise the care plan for the use of an indwelling urinary catheter. The DON confirmed staff should perform hand hygiene before and after removing gloves.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Green Hills Center for Rehabilitation and Healing		STREET ADDRESS, CITY, STATE, ZIP CODE 3939 Hillsboro Circle Nashville, TN 37215	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>38439</p> <p>Based on policy review, observation, and interview, the facility failed to ensure medications were properly stored in 3 of 9 (100 Hall Medication Cart #1, 200 Hall Medication Cart #1, and 300 Hall Medication Room) storage areas when external and internal medications were stored together and with toxic chemicals, medications stored opened and undated, and when discontinued medications were stored in the medication room, and when 1 of 9 (300 Hall Medication Cart #2) storage areas was left unsecure, unattended, and out of sight of the nurse</p> <p>The findings include:</p> <p>1. Review of the facility policy title, Medication Labeling and Storage, dated 5/19/2023, revealed .The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items .Compartments (including .drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such items are not left unattended if open or otherwise potentially available to others .Antiseptics, disinfectants, and germicides used in any aspect of resident care .shall be stored separately from regular medications .</p> <p>Review of the facility's policy titled Administering Medications, revised April 2019, revealed .During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide .The cart must be clearly visible to the personnel administering medications .</p> <p>2. Observation and interview on the 200 hall Medication Cart #1 on 1/30/2025 at 12:07 PM, revealed the following:</p> <p>a. 1 plastic container of (Named) Disinfectant wipes stored with heparin (blood thinner) 5ml (milliliter) lock flushes in the bottom drawer of the medication cart without a separation barrier.</p> <p>b. 1 box of [NAME] Pain Relief Gel Packets opened and undated</p> <p>c. oral medications of Azathioprine (medication used for rheumatoid arthritis) 50mg (milligram) tablets, Duloxetine (medication used for depression) 60mg capsules, Folic Acid (dietary supplement) 10mg tablets, Gemtesa (medication used for overactive bladder) 75mg tablets, cetirizine (allergy medication) 10mg tablets, methotrexate (medication used to treat cancer) 2.5mg tablets, stored in a plastic container without a barrier with the following medications used for skin irritation:</p> <p>An 8oz (ounces) bottle of 12% (percentage) ammonium lactate lotion (to treat dry, itchy, and scaly skin).</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A 2oz tube of 20% Zinc Oxide ointment</p> <p>A 4oz tube of calmoseptine ointment (protects and helps heal skin irritations).</p> <p>A 15 gram bottle of Nyamyc (to treat cutaneous and mucocutaneous infections).</p> <p>During an interview with Licensed Practical (LPN R), LPN R confirmed that internal medications should not be stored with external medications, and that toxic chemicals should not be stored with external or internal medications.</p> <p>3. Observation on the 100 Hall Medication Cart #1 on 1/30/2025 at 12:30 PM, revealed the following:</p> <p>a. A box of scopolamine transdermal patches (to prevent motion sickness and used in surgery) stored in a compartment without a barrier, with 2 Lantus Insulin injection pens and a vial of Ondansetron 4mg injection.</p> <p>b. A 32oz bottle of Critical Care LPS Liquid Protein oral supplement opened and undated.</p> <p>c. A bottle of SDS 15 gram oral suspension (used to treat yeast in the mouth) stored in a compartment with 2 bottles of Fluticasone (to relieve symptoms of rhinitis (stuffy nose)) 50mcg (microgram) nasal spray, 1oz bottle of nasal decongestant spray, 1oz (Named) nasal spray, 1.5oz bottle of deep sea nasal saline spray.</p> <p>During an interview on 1/30/2025 at 12:30 PM, Registered Nurse (RN HH) confirmed that internal and external medications should be stored separately and not with toxic chemicals. RN HH confirmed that all medications should be labeled with an opened date. RN HH confirmed that if medications are stored in the same compartment, they should have a divider to separate them, and that oral medications, ointments, and injections should not be stored with nasal medications.</p> <p>4. Observation on 1/31/2025 at 8:32 AM, revealed LPN O went into Resident #106's room to administer medications and left the 300 Hall Medication Cart #2 unsecured, unlocked, and out of sight.</p> <p>During an interview on 2/3/2025 at 8:55 PM, the DON was asked should the medication cart be left unlocked and out of sight of the nurse. The DON stated, No.</p> <p>5. Observation and interview in the 300 Hall Medication Room on 2/3/2025 at 11:47 AM, revealed 2.5% Hydrocortisone Cream (treats skin conditions) stored in the medication room cabinet, ordered for Resident #47. LPN Q confirmed the medication was discontinued and the resident no longer receives the medication. LPN Q confirmed that the medication should be sent back to pharmacy or discarded when it is discontinued and should not be stored in the cabinet.</p> <p>49269</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047</p> <p>Based on policy review, observation, and interview, the facility failed to ensure food was properly stored, prepared, and served under sanitary conditions, when the facility failed to ensure kitchen equipment was clean and sanitary, when food was stored opened, undated, and expired, when staff failed to cover hair, failed to perform hand hygiene, when food was left uncovered and unattended, and when the ice machine had pink and black build up. The facility served 119 meal trays.</p> <p>The findings include:</p> <p>1. Review of the facility's undated policy titled, Food and Sanitation, revealed .All local, state and federal standards and regulations are followed in order to assure a safe and sanitary food service department .Hair restraints are required and should cover all hair on the head .Beard nets are required when facial hair is visible .All staff will wash their hands just before they start to work in the kitchen and when they have used their hands in an unsanitary way .Foods are protected from contamination (dust, flies, rodents, and other vermin) .Foods with expiration dates are used prior to the use by date on the package .</p> <p>Review of the facility's undated policy titled, Food Storage, revealed .Sufficient storage facilities are provided to keep food safe, wholesome and appetizing. Food is stored in an area that is clean, dry, and free from contaminations .Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled with a date before being refrigerated. Leftover food is used within 3 days or discarded . Refrigerated Food Storage .All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be used by their safe use by dates, or frozen .or discarded .Frozen Foods . All foods should be covered, labeled and dated. All foods will be checked to assure that foods will be used by their safe use by dates or discarded .</p> <p>Review of the facility's undated policy titled, Cleaning Instructions: Ovens, revealed .Ovens will be cleaned as needed and according to the cleaning schedule (at least once every two weeks). Spills and food particles will be removed after each use .Remove spills and food particles after each oven use as needed (before re-heating the oven) .</p> <p>Review of the facility's undated policy titled, Cleaning Instructions: Ranges/Griddles, revealed .The range/griddle will be cleaned after and prior to each use. Spills and food particles will be wiped up as they occur .Scrape burned particles and grease off using proper cleaning items (a non-metal scouring pad may be needed for metal surfaces). Wipe the surface with a clean cloth soaked in soapy water .Spills should be cleaned up as they occur .</p> <p>Review of the facility's undated policy titled, Cleaning Instructions, revealed .Bin ice machine and equipment . will be cleaned and sanitized on a regular basis .Wash the interior thoroughly using a detergent solution. Rinse and drain the interior with clean hot tap water. Pay close attention to the crevices with maintenance assistance .Sanitize .</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's policy titled, Handwashing Hand Hygiene, dated [DATE], revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Hand hygiene is indicated .after contact with contaminated surfaces .immediately after removing gloves .The use of gloves does not replace hand washing/hand hygiene .Applying and Removing Gloves .Perform hand hygiene before applying gloves .</p> <p>2. Observation in the kitchen on [DATE] at 11:31AM, revealed the following:</p> <p>a. thick black buildup of an unknown substance on top of the cooking stove and the 2 eyes on the cooking stove.</p> <p>b. [NAME] W, [NAME] V with no facial hair covering.</p> <p>c. Black grease with brown crumbs in the deep fryer.</p> <p>d. A tomato, a bag of cheese, a bag of purple cabbage, a bag of carrots, sliced turkey in a clear package, and a bag of lettuce, on a metal prep table, opened and undated.</p> <p>e. Dark brown and black build up on the griddle.</p> <p>3. Observation of the kitchen dry storage room on [DATE] at 11:56 AM, revealed 12 cans of Raviolos De Carne De Res on a metal shelf, dated best if used by [DATE].</p> <p>4. Observation in the kitchen on [DATE] at 12:10 PM, revealed the following:</p> <p>a. Dietary Aide X had no facial hair covering.</p> <p>b. Dietary Aide Y had no hairnet on.</p> <p>c. Dietary Aide Z failed to perform hand hygiene before putting on gloves to prepare food.</p> <p>5. Observation in the kitchen in the freezer on [DATE] at 12:15 PM, revealed the following:</p> <p>a. 3 plastic bags of meat unlabeled, undated</p> <p>b. A bag of okra, undated.</p> <p>c. A bag of vegetables, opened, unsealed and undated.</p> <p>d. A bag of cookie dough, opened, unsealed, and undated.</p> <p>e. A bag of cheese pizza opened, unsealed and undated.</p> <p>h. 12 bags chopped turnip greens, undated.</p> <p>i. A bag of broccoli, undated.</p> <p>6. Observation in the kitchen on [DATE] at 10:09 AM, revealed</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. Chef DD had no facial hair covering.</p> <p>b. Dietary Aide AA failed to properly perform hand hygiene before food preparation.</p> <p>c. Dietary Aide CC had no facial hair covering and had no hairnet on.</p> <p>d. A thick black buildup of an unknown substance on top of the cooking stove and the 2 eyes on the cooking stove.</p> <p>e. [NAME] V had no facial hair covering.</p> <p>f. A black buildup of an unknown substance inside the ovens and brown buildup of an unknown substance on the inside of the ovens' doors.</p> <p>7. Observation in the kitchen in the walk-in cooler on [DATE] at 10:23 AM, revealed the following:</p> <p>a. 3 containers of Cottage Cheeses dated use by [DATE].</p> <p>b. 11 packages of turkey bacon slices, opened and undated.</p> <p>c. An unidentified meat, opened, undated, unlabeled.</p> <p>8. Observations in the kitchen on [DATE] at 11:25 AM, revealed [NAME] V used his gloved hands to scoop an identified liquid off the floor, removed his gloves, and failed to perform hand hygiene before putting on another pair of gloves. There was a pan of noodles and a pan of meat, uncovered and unattended, on a rolling cart and [NAME] V, Chef DD, and Dietary Aide CC had no facial hair covering.</p> <p>9. Observations in the kitchen on [DATE] at 12:04 PM, revealed [NAME] V on the food line and failed to have a facial hair and hair covering. [NAME] V removed his gloves, began to take the tray line food temperature without performing hand hygiene and without wearing gloves.</p> <p>10. Observations and interview in the kitchen on [DATE] at 1:53 PM, revealed the plastic white flap inside the ice machine had 2 rusted screws, a cluster of small black dots centered in the middle of the flap, and an unknown pink substance on the lower right edge of the flap, black build up on the 2 grooves of the plastic flap where the plastic flap and the metal of the ice machine meet, and the upper corners of rubber trim inside of the lid. The Regional Food and Nutrition Director confirmed there should be no rusted screws, no black build up, and no pink substance inside of the ice machine.</p> <p>During an observation and interview in the kitchen on [DATE] at 3:31 PM, the Maintenance Director was shown the ice machine and confirmed the black substance was mold.</p> <p>11. Observations in the kitchen in the food prep area on [DATE] at 4:13 PM, revealed an unattended and uncovered pan of cooked meat, cooked bacon, baked apples, and instant potatoes.</p> <p>(continued on next page)</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an observation and interview on [DATE] at 4:20 PM, the Regional Food and Nutrition Director confirmed food should be covered when left unattended, confirmed the thick black build up on top of cooking stove and the 2 eyes needed to be removed, confirmed the black build up inside the ovens and the brown build up on the inside of the ovens' doors needed to be removed, and confirmed the griddle needed to be cleaned to remove the dark brown and black build up.</p> <p>12. Observations in the kitchen dishwashing room on [DATE] at 9:19 AM, revealed Assistant Dietary Manager BB failed to perform hand hygiene before applying gloves and placed clean dishes on a soiled rolling cart.</p> <p>During an interview on [DATE] at 4:54 PM, the Regional Food and Nutrition Director confirmed facial hair and hair should be covered with a net, confirmed dietary staff should perform hand hygiene whenever entering the kitchen, whenever removing gloves and before donning clean gloves, and confirmed carts should be cleaned before placing clean dishes on them.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974</p> <p>Based on the Center for Disease Control (CDC) guidelines, policy review, medical record review, observation, and interview, the facility failed to ensure proper infection control practices were followed when 2 of 2 staff members (Certified Nurse Assistant (CNA S) and Licensed Practical Nurse (LPN O) failed to properly store soiled linens, and wear Personal Protective Equipment (PPE) for Enhanced Barrier Precautions (EBP), and failed to properly disinfect reusable medical equipment.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of the CDC guidelines dated 6/28/2024, revealed .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [Multi-Drug Resistant Organism] . 2. Review of the facility's policy titled, Cleaning Guidelines for the Prevention of Covid-19, dated 3/29/2022, revealed .Compliance with Infection Prevention .Use proper hand hygiene and PPE at all times . Increase the cleaning and disinfecting of high-touch items and surfaces in the following areas . Clinical Care Equipment . General Shared Equipment . 3. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Hypertension, Heart Failure, and Absence of Right Toe. <p>Review of the admission [NAME] Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #7 had intact cognition.</p> <p>Review of the Physician's Order dated 11/19/2024, confirmed Resident #7 had an order for Enhanced Barrier Precautions related to a wound on the right foot.</p> <p>A random observation in Resident #7's room and interview on 1/27/2025 at 12:46 PM, revealed soiled linen lying on the floor of Resident's #7's room. CNA S confirmed she placed the soiled linen on the floor.</p> <ol style="list-style-type: none"> 4. Review of the medical record revealed Resident #77 was admitted to the facility on [DATE], with diagnoses including Guillain Barre Syndrome, Hypertension, Diabetes, Hemiplegia, Anxiety, and Asthma. <p>Review of the quarterly MDS dated [DATE], revealed a BIMS score of 13, which indicated Resident #77 was cognitively intact and had a Stage 4 pressure wound.</p> <p>During an observation and interview on 1/27/2025 at 4:23 PM, revealed LPN O was asked to come to Resident #77's room and was asked if soiled linen should be left in the resident's floor. LPN O confirmed soiled linen should not be left in the floor in residents' room. LPN O kicked the soiled linen with his foot behind the resident door and exited Resident #77's room.</p> <p>During an observation on 1/27/2025 at 4:27 PM, LPN O donned gloves and removed the soiled linens from Resident #77's floor and failed to don PPE for EBP.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Review of the medical record revealed Resident #106 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Human Immunodeficiency Virus [HIV] Disease, Atrial Fibrillation, and Aphasia.</p> <p>Observation on 1/31/2025 at 8:39 AM, revealed LPN O went in to Resident #106's room and placed the blood pressure machine on the left wrist and the pulse oximeter on the resident's finger. LPN O placed the blood pressure cuff and pulse oximeter into the top pocket of his scrub shirt once he obtained the results. LPN O exited the room and returned to the medication cart, placed the blood pressure cuff and the pulse oximeter into the medication cart drawer, and failed to clean or disinfect the reusable equipment.</p> <p>During an interview on 2/3/2025 at 8:04 PM, the Director of Nursing (DON), confirmed that soiled linens should not be left on the resident's floor, and staff should wear a gown and gloves in a resident's room who is in EBP.</p> <p>During an interview on 2/3/2025 at 8:53 PM, the DON confirmed reusable resident equipment should be disinfected after use.</p> <p>46047</p>