STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445270	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee Veterans Home	345 Compton Road Murfreesboro, TN 37130

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 0600 Level of Harm - Minimal harm or potential for 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** 18750 Based on policy review, medical record review, and interview, the facility failed to ensure residents were free from physical abuse during two separate incidents on 07/29/24 and 08/21/24 that involved three of eight residents (Resident (R) 209, R76, and R54) reviewed for abuse. Findings include: 1. Review of the facility's policy titled, Abuse & Neglect and Misappropriation of Residents' Property, revised on 11/09/16, revealed Policy Statement: In keeping with our facility philosophy and to promote the total well-being of our residents through the provision of the highest quality of care with the goal of maintaining or enhancing each resident's functional level and quality of life .[name of facility] takes a firm stand on the issues of mistreatment, neglect, or abuse of the residents and misappropriation of the resident's property. Each resident is to be treated at all times with courtesy and respect, and full recognition of the individual's dignity and individuality. Every resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion. Residents must not be subjected to abuse from anyone, including, but not limited to .other residents . 2. a. Review of R209's undated Admission Record, provided by the facility, revealed R209 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of cerebral infarction, type two diabetes, and cerebral vascular disease affecting left side. Review of R209's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 05/06/24, revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15 indicating moderate cognitive impairment. b. Review of R76's undated Admission Record, provided by the facility, revealed R209 was admitted to the facility on [DATE], with a readmission on 09/22/23, and diagnoses of unspecified dementia, with agitation, adjustment disorder with depressed mood, and fracture of part of neck left femur. Review of R76's quarterly MDS with an ARD of 06/25/24, revealed a BIMS score of five out of 15 which indicated severe cognitive impairment. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445270	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2025

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F 0600

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Review of the facility investigation, provided by the facility, revealed on 07/29/24, a Certified Nurse Technician (CNT) reported to the Nursing Manager that R209 struck the hand of R76 when R76 attempted to move R209's wheelchair out of the line of travel.

During an interview on 01/29/25 at 2:06 PM, the Director of Nursing (DON) was asked if she recalled the incident. The DON stated, This happened in the room and [R209] was getting ready for an appointment. [R76] was in line of travel and [R209] hit [R76] on the hand. It was witnessed by an agency CNT who no longer works here.

3. Review of R54's undated Admission Record, provided by the facility, revealed R54 was admitted to the facility on [DATE], with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting dominant side, post-traumatic stress disorder, and cognitive social or emotional deficit following cerebrovascular disease.

Review of R54's quarterly MDS with an ARD of 06/17/24, revealed a BIMS score of 14 out of 15 indicating intact cognition.

Review of the facility investigation, provided by the facility, revealed on 08/21/24, R76 was exiting the dining room in his wheelchair. R54 was behind him. R54 pushed R76 through the open door then physically struck him approximately three times on the back with an open hand.

During an interview on 01/28/25 at 10:11 AM, R54 was asked what he could recall about the incident. R54 said, The staff said I hit him on the head, but I did not. They said they have it on film.

During an interview on 01/29/25 at 2:06 PM, the DON recalled R54 was trying to come out of the dining room but R76 was in front of him. The DON stated R54 hit R76 on the head. The DON stated, I asked R54 what happened, and he stated he did not like R76.

During an interview on 01/30/25 at 10:50 AM, Certified Nurse Aide (CNA) 4 was asked if he could recall what took place between R54 and R76. CNA 4 stated, [R54] was trying to leave the dining room and [R76] was also trying to leave at the same time. [R76] is slow. [R54] kept telling him to go faster and he grew more impatient. [R54] began kicking at the wheelchair and hit [R76] three times in the back. I intervened and got [R76] out. You could tell he was scared.

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F 0623

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 18750

Based on facility policy review, record review, and interview, the facility failed to ensure three out of three residents (Resident (R) 49, R259, and R76) and/or their representatives reviewed for hospitalization were provided with written transfer notices upon emergent transfer to the hospital and ensure notification was provided to the ombudsman.

Findings include:

1.Review of the facility policy titled, Resident Discharge Policy, approved on 11/11/13, revealed Policy .will give timely and proper notice for any intent to transfer or discharge a resident when permitted by Federal or State rules .Procedure .(i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the transfer or discharge in writing and in a language and manner they understand (include letter) . (iii) Notify the Department of Health and the Long-Term Care Ombudsman (facility responsibility) .

2. Review of R49's Resident Detail located in the electronic medical record (EMR) in the banner under Demographics indicated that he was admitted to the facility on [DATE].

Review of R49's Medical Diagnosis list located in the EMR under the Diagnosis tab had a primary diagnosis of Alzheimer's Disease.

Review of R49's discharge return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital.

Review of R49's Progress Note located in the EMR under the Progress Note tab, dated 08/23/24 at 11:58 AM, revealed Resident was outside in his w/c [wheelchair] when he suddenly became unresponsive. Nurses responded to this and resident responded when staff sternum rubbed resident. Was reported to this nurse that V/S [vital signs] were not WNL [within normal limits], O2 [oxygen], BP [blood pressure], and P [pulse] were all low. EMS [emergency medical services] was called and resident was taken by EMS to ER [emergency room]. Family being notified now.

Review of R49's Progress Note located in the EMR under the Progress Note tab, dated 08/24/24 at 1:39 PM, revealed Resident returned back to the facility via ambulance. Transported to facility room via stretcher. Pleasantly confused .Wet cough still present .

Review of R49's EMR and paper chart did not include a transfer/discharge written notification to the resident/responsible party and the Ombudsman.

3. a. Review of R259's Admission Record, provided by the facility, indicated that he was originally admitted to the facility on [DATE], with a primary diagnosis of quadriplegia.

Review of R259's discharge return anticipated MDS with an ARD of 09/13/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital.

(continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tennessee Veterans Home	345 Compton Road Murfreesboro, TN 37130

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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 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R259's entry MDS with an ARD of 09/25/24, and located in the EMR under the MDS tab, indicated R259 returned to the facility on [DATE], from a short-term general hospital. b. Review of R259's discharge return not anticipated MDS with an ARD of 10/31/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital. Review of R259's Progress Note located in the EMR under the Progress Note tab, dated 09/13/24 at 1:45 PM, revealed Resident transferred to [hospital name] .per ambulance . Review of R259's Progress Note located in the EMR under the Progress Note tab, dated 09/25/24 at 4:43 PM, revealed Resident .admitted from [hospital name] around 11:35 AM . Review of R259's Progress Note located in the EMR under the Progress Note tab, dated 10/31/24 at 11:16 PM, revealed Resident was sent to [hospital name] for eval (evaluation) and treatment. Review of R259's EMR and paper chart did not include a transfer/discharge written notification to the resident/responsible party and the Ombudsman. During an interview on 01/29/25 at 6:09 PM, Licensed Practical Nurse (LPN) 7 stated that once the nurse received an order from the physician to send the resident to the hospital, a packet was made including the face sheet, medication list, and advance directive. LPN7 stated there was a Transfer Cover Sheet that was to be attached to each of the three copies (facility copy, paramedic copy, and hospital copy). Review of the blank facility document titled, Transfer Cover Sheet included the following: resident name, transfer date/time, reason for transfer, who was notified, clinical information, and whether a Bed Hold was provided and signed. LPN7 stated that this document was supposed to be filled out with each hospitalization . 4. a. Review of R76's quarterly MDS with an ARD of 06/25/24, in the EMR under the MDS tab revealed the facility assessed R76 to have a BIMS score of five out of 15 which indicated the resident had severe cognitive impairment. Review of R76's Progress Note, dated 05/20/24, and located in the EMR under the Progress Notes tab, revealed the resident was sent to the hospital for psych issues. R76 returned to the facility on [DATE]. Review of the complete medical record for R76 revealed no evidence that a written transfer was provided to the resident and/or representative. b. Review of R76's quarterly MDS with an ARD of 12/20/24, in the EMR under the MDS tab revealed the facility assessed R76 to have a BIMS score of three out of 15 which indicated the resident had severe cognitive impairment. Review of R76's Progress Note, dated 01/07/25, and located in the EMR under the Progress Notes tab, revealed the resident was sent to the hospital for fall issues. R76 returned to facility on 01/22/25. Review of the complete medical record for R76 revealed no evidence that a written transfer was provided to the resident and/or representative. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 01/29/25 at 8:30 AM, the Assistant Director of Clinical Services (ADCS) stated there were no transfer notifications in writing sent to family or ombudsman. We were not aware that notice had to be in writing to family. We did know that it had to be sent to the ombudsman and that has not been done. 40824

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 18750 Based on facility policy, record review, and interview, the facility failed to ensure a written copy of a bed hold notice prior to or within 24 hours of transfer to the hospital was provided for three of three residents (Resident (R) 49, R259, and R76) and/or their representatives reviewed for hospitalization out of 31 sample residents. Findings include: 1.Review of the facility's policy titled, Bed Hold Notice-Hospital and therapeutic Leave, revised 07/18, revealed If a resident of this facility is hospitalized or on therapeutic leave, the following is our established policy to hold a bed or room for return: policy is to allow a bed hold agreement for hospital, therapeutic, or a leave of absence to not exceed 10 days. If a resident requests to hold a bed for longer than 10 days, another bed hold agreement for additional days, not to exceed 10, may be completed. There is no limit on the amount of bed hold agreements that can run consecutively . 2. Review of R49's Resident Detail located in the electronic medical record (EMR) in the banner under Demographics indicated that he was admitted to the facility on [DATE]. Review of R49's Medical Diagnosis list located in the EMR under the Diagnosis tab had a primary diagnosis of Alzheimer's Disease. Review of R49's discharge return anticipated Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/23/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital. Review of R49's Progress Note located in the EMR under the Progress Note tab, dated 08/23/24 at 11:58 AM, revealed Resident was outside in his w/c [wheelchair] when he suddenly became unresponsive. Nurses responded to this and resident responded when staff sternum rubbed resident. Was reported to this nurse that V/S [vital signs] were not WNL [within normal limits], O2 [oxygen], BP [blood pressure], and P [pulse] were all low. EMS [emergency medical services] was called and resident was taken by EMS to ER [emergency room]. Family being notified now. Review of R49's Progress Note located in the EMR under the Progress Note tab, dated 08/24/24 at 1:39 PM, revealed Resident returned back to the facility via ambulance. Transported to facility room via stretcher. Pleasantly confused .Wet cough still present . Review of R49's EMR and paper chart did not include Bed Hold Notification or reserve bed payment information. 3. a. Review of R259's Admission Record provided by the facility indicated that he was originally admitted to the facility on [DATE], with a primary diagnosis of quadriplegia. (continued on next page)

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R259's discharge return anticipated MDS with an ARD of 09/13/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital. Review of R259's entry MDS with an ARD of 09/25/24, and located in the EMR under the MDS tab indicated R259 returned to the facility on [DATE], from a short-term general hospital. b. Review of R259's discharge return not anticipated MDS with an ARD of 10/31/24, and located in the EMR under the MDS tab indicated an unplanned discharge to short-term general hospital. Review of R259's Progress Note located in the EMR under the Progress Note tab, dated 09/13/24 at 1:45 PM, revealed Resident transferred to [hospital name] .per ambulance . Review of R259's Progress Note located in the EMR under the Progress Note tab, dated 09/25/24 at 4:43 PM, revealed Resident .admitted from [hospital name] around 11:35 AM . Review of R259's Progress Note located in the EMR under the Progress Note tab dated 10/31/24 at 11:16 PM, revealed Resident was sent to [hospital name] for eval (evaluation) and treatment. Review of R259's EMR and paper chart did not include Bed Hold Notification or reserve bed payment information. During an interview on 01/29/25 at 6:09 PM, Licensed Practical Nurse (LPN) 7 stated that once the nurse received an order from the physician to send the resident to the hospital, a packet was made including the face sheet, medication list, and advance directive. LPN7 stated there was a Transfer Cover Sheet that was to be attached to each of the three copies including a Bed Hold. Review of the blank facility document titled, Transfer Cover Sheet included the following: resident name, transfer date/time, reason for transfer, who was notified, clinical information, and whether a Bed Hold was provided and signed. LPN7 stated additionally, if this was sent out there would be a copy in the paper chart. 4. a. Review of R76's quarterly MDS with an ARD of 06/25/24, in the EMR under the MDS tab revealed the facility assessed R76 to have a BIMS score of five out of 15 which indicated the resident had severe cognitive impairment. Review of R76's Progress Note dated 05/20/24, in the EMR under the Progress Notes tab, revealed the resident was sent to the hospital for psych issues. R76 returned to the facility on [DATE]. Review of the complete medical record for R76 revealed no evidence that a written bed hold was provided to the resident and/or representative. b. Review of R76's quarterly MDS with an ARD of 12/20/24, in the EMR under the MDS tab revealed the facility assessed R76 to have a BIMS score of three out of 15 which indicated the resident had severe cognitive impairment. Review of R76's Progress Note, dated 01/07/25 in the EMR under the Progress Notes tab, revealed the resident was sent to the hospital for fall issues. R76 returned to facility on 01/22/25. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the complete medical record for R76 revealed no evidence that a written bed hold was provided to the resident and/or representative. During an interview on 01/29/25 at 8:30 AM, the Assistant Director of Clinical Services (ADCS) stated there were no bed hold notifications in writing sent to the resident or family. The ADCS stated, The north unit is closed, and we just have not done any because they can come back. 40824

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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 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** 25490 Based on facility policy review, record reviews, and interview, the facility failed to follow the physician's orders which included notifying the physician of blood sugar levels above 300 milligrams/deciliter (mg/dL) for one of one resident (Resident (R) 20) of 31 sample residents. Findings include: 1.Review of the facility's policy titled, Notification of Changes Policy, dated 01/07/13, revealed, .the facility will promptly consult with the attending physician and notify the resident's responsible party when there is a need to alter treatment . 2. Review of R20's undated Admission Record, provided by the facility, revealed an admitted [DATE], with diagnoses to include type two diabetes, peripheral vascular disease, pressure ulcer of other sites, stage two, and end-stage renal disease. Review of R20's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/10/25, located in the electronic medical record (EMR) under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R20 was cognitively intact. Review of R20's Orders under the Orders tab in the EMR, revealed .Obtain and record [Accu-check] blood sugars, [Accu-Chek is a brand of blood glucose meters and supplies that are used to measure patients glucose levels] .Notify MD [Medical Doctor] if blood sugar is less than 60 or greater than 300 before meals and at bedtime Review of the Medication Administration Record (MAR) located in the EMR under the Reports tab, revealed before lunch Accu-Chek readings exceeding 300 mg/dL on 01/14/25 with glucose reading of 382, on 01/18/25 with glucose reading of 336, on 01/22/25 with glucose reading of 305, on 01/28/25 with glucose reading of 304. The following glucose readings were attained before dinner and exceeded 300 on the following days, on 01/08/25 with a glucose reading of 300, on 01/11/25 with a glucose of 330, on 01/17/25 with a glucose reading of 342, on 01/22/25 with a glucose reading of 300, on 01/26/25 with a glucose reading of 416 and on 01/27/24 with a glucose reading of 331. Review of R20's Progress Notes under the Progress Note tab revealed no nurse's notes indicating that the MD was notified of glucose levels over 300. During an interview on 01/30/25 at 12:01 PM, the Unit Manager (UM) 2 reviewed R20's EMR and confirmed that R20's glucose levels were 300 or over on 10 occasions. UM2 continued to review R20's progress notes and confirmed that the MD was not notified according to the doctor's orders. UM2, further stated, I expect my nursing staff to follow doctor's orders at all times . During an interview on 01/30/25 at 12:15 PM, the Physician Assistant (PA) revealed that she or the MD should have been notified according to the doctor's orders. During an interview on 01/30/25 at 1:07 PM, the Director of Nursing (DON) revealed that her expectation of the facility staff was to follow the MD orders and document in the EMR.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 18750 Based on facility policy review, observation, and interview, the facility failed to ensure staff performed handwashing after glove contamination while serving on the tray line in one of one kitchen. These failures had the potential to affect 100 of 104 residents who consumed food prepared in the kitchen by the facility kitchen. Findings include: 1.Review of the facility's policy titled, Dietary Policies Personal Hygiene- Dress Code with an approval date of 09/05/18, revealed Policy Statement .guidelines for the personal hygiene of dietary staff to promote a safe and sanitary department must be followed. Procedures .8) Hand Washing: Staff must wash their hands . touching their hair, hat, nose, or mouth .9) Gloves . Gloves must be changed as often as hands need to be washed. Gloves may be used for one task Only . 2. During an observation of the tray line on 01/30/25 at 11:56 AM, Dietary [NAME] (DC) 1 was observed to be placing food on the trays and placing them in the cart for transport. DC1 was observed to run his right gloved hand under his nose, and he proceeded to set up trays. At 12:03 PM, the DC1 was observed to run his right gloved hand under his nose again, without handwashing. During an interview on 01/30/25 at 12:05 PM, the DC1 was asked about running his gloved hand under his nose. DC1 stated, I should have washed my hands. During an interview on 01/30/25 at 12:06 PM, the Dietary Manager (DM) was told about the observation. The DM stated, The Staff should have taken the gloves off and washed his hands both times.

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 18750 Based on facility policy review, observation, and interview, the facility failed to ensure the dumpster had lids to properly confine the refuse inside and prevent rodents or other animals from getting in for two of two trash dumpsters and one of one carboard dumpster. Findings include: 1.Review of the facility's policy titled, Food-Related Garbage & Rubbish Disposal with an approved date of 05/13/15, revealed Policy: Food-related garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. Policy Interpretation: 1. All garbage and rubbish containing food wastes shall be kept in containers. 2. All garbage and rubbish containers shall be provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use .5. Garbage and rubbish containing food waste will be stored in a manner that is inaccessible to vermin .7. Outside dumpsters provided by garbage pick-up services will be kept closed and free of surrounding litter. 2. During the initial tour of the kitchen on 01/27/25 at 10:03 AM, an observation was made of the dumpster. The trash was piled high and not contained within the dumpster. The Dietary Manager (DM) and Maintenance Director (MD) were also present and were asked if it was appropriate for the trash to be to be piled and seen not to be covered by lids. The DM stated, I don't think there are lids on top of the dumpster. The DM and MD both stated it should not be piled up and there should be lids to contain the trash. They were also asked why it was important to have lids and a closed dumpster. The DM stated, To keep the trash in and the varmints out. The DM also stated the dumpster should be emptied today. During an observation on 01/27/25 at 4:25 PM, one bag of trash was observed to be sitting on top of the dumpster. During an observation on 01/28/25 at 2:05 PM, an unidentified staff was seen throwing three bags of trash up into the dumpster with no lids. During an observation on 01/28/25 at 2:16 PM, an unidentified staff member was seen throwing eight bags of trash into the dumpster with no lids. During an interview on 01/30/25 at 4:28 PM, the Maintenance Director (MD) was asked about the dumpster having no lids. The MD stated, The dumpster should have lids to contain it. The MD was told about the observations of staff continuing to throw trash into the dumpster with no lid after the initial observation on 01/27/25. The MD stated staff needed to be retrained.