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	05/06/2026

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to provide wound care treatment as ordered by the Physician for 3 of 4 (Resident #11, #65, and #67) sampled residents reviewed for pressure ulcers. The findings include: 1. Review of the facility policy titled, Pressure Ulcer Policy, dated 1/7/2013, revealed .residents who are admitted with pressure ulcers receive the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Review of the facility policy titled, Medication Administration-General Guidelines, dated 1/1/2018, revealed .Medications are administered as prescribed in accordance with good nursing principles and practices.The medication administration record (MAR) is always employed during medication administration.Medications are administered in accordance with written orders of the prescriber.The individual who administers the medication dose records the administration on the resident's MAR/eMAR [electronic medication administration record] directly after the medication is given.In no case should the individual who administered the medications report off-duty without first recording the administration of any medications.The resident's MAR/eMAR is initialed by the person administering the medication, in the space provided. 2. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE], with diagnoses including Depression, Vitamin D Deficiency, Kidney Failure, Diabetes, Acidosis, and Severe Protein-Calorie Malnutrition.^ ^ Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was severely cognitively impaired and had 2 stage 3 (a wound that breaks through the skins top 2 layers) pressure ulcers. ^ Review of the Treatment Administration Record (TAR) dated 3/2026, revealed the Physician's order dated 3/3/2026 and discontinued on 4/6/2026, stated .Coccyx [tailbone] .Cleanse with normal saline, pat dry, pack with collagen and cover with border foam dressing daily and as needed x [times] 14 days then re-evaluate. The facility failed to provide treatment for Resident #11's coccyx wound on 3/7/2026, 3/8/2026, and 3/9/2026. (continued on next page)

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the TAR dated 4/2026, revealed the Physician's order dated 4/8/2026 and discontinued on 4/23/2026, stated .Coccyx .Cleanse with normal saline, pat dry, pack with collagen [a medication used on pressure ulcers to promote growth of new tissue] and cover with border foam dressing QOD [every other day] and as needed x 14 days then re-evaluate. The facility failed to provide treatment for Resident #11's coccyx wound on 4/11/2026 and 4/19/2026. Review of the TAR dated 4/2026, revealed the Physician's order dated 4/24/2026 and discontinued on 4/28/2026, stated .Coccyx .Cleanse with normal saline, pat dry, pack with collagen and cover with border foam dressing QOD and as needed x 14 days then re-evaluate. The facility failed to provide treatment for Resident #11's coccyx wound on 4/24/2026 and 4/26/2026. During an interview on 5/6/2026 at 4:09 PM, the Wound Care Nurse was asked how do you know if wound care treatments are completed. The Wound Care Nurse stated, By looking at the MAR. The Wound Care Nurse was asked what does a blank space on the MAR or TAR mean. The Wound Care Nurse stated, I would assume it [the treatment] wasn't done. The Wound Care Nurse was asked while looking at 4/2026 TAR if Resident #11 received wound care treatments during the time frame between 4/21/2026-4/27/2026. The Wound Care Nurse stated, It doesn't look like it. During an interview on 5/6/2026 at 5:14 PM, the Director of Nursing (DON) was asked if she expected wound care to be provided as ordered by the Physician. The DON stated, Yes. The DON was asked how she knew if wound care was provided as ordered. The DON stated, It is marked [signed off] on the TAR.^ The DON was asked what does the blank spaces on the MAR or TAR mean. The DON stated, I would assume it was not done. The DON was asked if the TAR should have blank spaces on it. The DON stated, It should not. The DON was asked if wound care should be provided to residents on the weekends as ordered by the physician. The DON stated, Yes. The DON was asked while looking at the TAR dated 4/2026, if Resident #11 received wound care treatments during the time frame between 4/21/2026-4/27/2026. The DON stated, Looking at this, No. 3. Review of the medical record revealed Resident #65 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, Heart Failure, Epilepsy, Insomnia, and Adult Failure to Thrive. Review of the admission MDS assessment dated [DATE], revealed Resident #65 scored a 3 on the BIMS assessment, which indicated he was severely cognitively impaired and had 1 Unstageable (a wound covered in dead tissue and unable to see wound bed) Pressure Ulcer to right dorsal (top) foot. Review of the TAR dated 4/2026, revealed the Physician's Order dated 4/28/2026, stated Right dorsal foot .cleanse with [Named wound cleanser], pat dry, apply [Named Brand wound care honey] and cover with small piece of hydrofera blue [antibacterial foam that promotes healing and reduces bioburden], then cover with border foam dressing daily and as needed x 14 days then re-evaluate . The facility failed to provide treatment for Resident # 65's right dorsal foot wound on 4/11/2026, 4/12/2026 and 4/26/2026. During an interview on 5/5/2026 at 2:36 PM, the Wound Care Nurse was asked when Resident #65's wound was discovered. The Wound Care Nurse stated .on 3/31/26 [Resident #65] was found with an unstageable wound and it had eschar [dead, non-viable tissue] and a week later it was moist that turned to yellow slough [non-viable tissue that accumulates on the surface of a wound]on 4/7/2026 and then 4/29/2026, we are at pink moist tissue. He has no necrotic tissue [dead, non-viable tissue], and the depth is < [less than] 0.1[centimeter]. Hospice and MD [Medical Director] are aware, and the hospice nurse comes in weekly to access the wound with me. We've tried off loaded boots and he (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refuses, so we try to float on pillows. 4. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Atherosclerotic Heart Disease, Cellulitis, Dementia, Retention of Urine. Review of the quarterly MDS assessment dated [DATE], revealed Resident #67 scored a 15 on the BIMS assessment, which indicated he was cognitively intact and had 1 Unstageable Pressure Ulcer – Deep Tissue Injury (pressure related injury affecting underlying tissue (DTI) to the right heel. Review of the TAR dated 4/2026, revealed the Physician's order dated 4/27/2026, stated [Named Pressure Reliving] boots as tolerated. Ensure on Q [every] shift. Document refusal every shift and 4/28/2026 0915 [AM] Right heel: apply skin prep and cover with heel foam dressing daily and as needed x 14 days then re-evaluate every .day shift for DTI for 14 Days AND as needed. The facility failed to provide treatment for the Resident #67's right heel wound on 4/11/2026, 4/18/2026, 4/19/2026, 5/2/2026 and 5/3/2026. During an Interview on 5/06/2026 at 8:19 AM, the Wound Care Nurse was asked if she was aware of wound care treatments not being done on the weekends. The Wound Care Nurse stated, It is audited weekly by the IP [Infections Preventionist] nurse and reported to [Named DON]. You would have to talk to the DON During an interview on 5/06/2026 at 8:25 AM, the DON was asked if she was aware of the missing treatments on the weekends. The DON stated, We are trying to have a wound care nurse here every weekend for 4-6 hours a day. That is something that we are implementing. The other thing is to make sure the RN [Registered Nurse] supervisor looks at that and does a double signoff to make sure that treatments are completed before they leave. This is something that I will put out today to ensure treatments are not being missed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen for 3 of 7 (Resident #38, #48, and #94) residents reviewed for respiratory care. The findings include: 1. Review of the facility policy titled, Oxygen Policy, dated 2/20/2013, revealed .Oxygen will only be administered with a Physician's order. Review of the facility policy titled, Medication Administration-General Guidelines, dated 1/1/2018, revealed .Medications are administered as prescribed in accordance with good nursing principles and practices.The medication administration record (MAR) is always employed during medication administration.Medications are administered in accordance with written orders of the prescriber. Review of the facility policy titled, Clinical Comprehensive Care Plans Policy, dated 3/1/2016, revealed .The Comprehensive Plan of Care will be individualized and include measurable objectives and timetables to meet the Resident's medical, nursing, mental and psychological needs .The Comprehensive Plan of Care will be updated/revised as warranted by condition changes . 2. Review of the medical record revealed Resident #38 was admitted to the facility on [DATE], with diagnoses including Acute Respiratory Failure with Hypoxia, Post-Traumatic Stress Disorder, Hypertension, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #38 scored a 99 on the Brief Interview for Mental Status (BIMS) assessment, which indicated severe cognitive impairment as the resident was unable to complete the assessment and received oxygen therapy. Review of the Care Plan dated 4/10/2026, revealed .RESPIRATORY .I have potential for respiratory distress related to weakness, impaired mobility, aging, and potential medication side effects .Administer oxygen therapy as ordered . Review of the Physician's Order dated 5/5/2026, revealed .1/27/2026 [start date].Oxygen at 1L/min [liter per minute] via [by way of] nasal cannula continuous to maintain oxygen saturation of >90% [greater than 90 percent] . During an observation in Resident #38's room on 5/4/2026 at 8:54 AM,11:38 AM and 3:08 PM, revealed Resident #38 oxygen was being administered at 2.5 L/min via nasal cannula. During an observation and interview in Resident #38's room on 5/5/2026 at 8:56 AM, Licensed Practical Nurse (LPN) B was asked what the physician's order was for Resident #38's oxygen. LPN B stated, 1 Liter per minute by nasal cannula. LPN B was asked what Resident #38's oxygen was currently set on. LPN B stated, Looks like 3 [L/min]. LPN B was asked at what rate Resident #38's oxygen should be administered. LPN B stated, 1 [L/min]. During an interview on 5/6/2026 at 5:14 PM, the Director of Nursing (DON) was asked what do you expect a resident's oxygen to be administered at if the physician's order is for 1L/min. The DON stated, 1 Liter. The DON was asked if Resident #38 should have been administered oxygen at 3 L/min. The DON stated, No, it should be at 1 [L/min]. 3. Review of the medical record revealed Resident #48 was admitted to the facility on [DATE], with diagnoses including Dementia, Obstructive Sleep Apnea (OSA), Congestive Heart Failure (CHF) and Chronic Atrial Fibrillation. Review of the Physician Order dated 7/15/2025, revealed Oxygen at 2L/min via nasal cannula as needed to maintain oxygen saturation of >90%^as needed [PRN]. ^ Review of the quarterly MDS assessment dated [DATE], revealed Resident #48 scored a 13 on the BIMS assessment, which indicated Resident #48 was cognitively intact and Oxygen therapy was noted as No.^ Review of the Care Plan dated 4/16/2026, revealed .I have potential for respiratory distress related to allergies, CHF, OSA and the aging process.Administer respiratory medications as ordered.10/22/2025. The care plan did not reflect oxygen use. Review of the MAR dated 4/2026, revealed PRN oxygen 2 L/min administration was signed off on 4/30/2026 only.^ Review of the Medication Administration Record (MAR) dated 5/2026, revealed PRN oxygen 2 L/min administration was not signed off.^ Observation in Resident #48's room on 5/04/2026 at 11:14 AM and 3:46 PM, revealed resident in bed with oxygen at 3 L/min via nasal cannula in use. During an observation and interview in Resident #48's room on 5/04/2026 at 4:30 PM, LPN A confirmed the oxygen was being administered at 3 L/min. LPN A was (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	asked what Resident #48's order for oxygen was. LPN A stated, .the order says oxygen at 2 liters as needed. During an interview on 5/6/2026 at 3:52 PM, the DON was asked if staff should follow physician orders related to medication. The DON stated, Yes. The DON was asked if medication orders include oxygen orders. The DON stated, Yes. The DON was asked if prn oxygen therapy should be signed off on the MAR when administered. The DON stated, It should. The DON was asked if a resident is receiving oxygen therapy, should that be reflected on their care plan. The DON stated, It should. 4. Review of medical records revealed Resident #94 was admitted to the facility on [DATE], with diagnoses including Dementia, Adult Failure to Thrive, and Emphysema. Review of the quarterly MDS assessment dated [DATE], revealed Resident #94 scored a 14 on the BIMS assessment, which indicated Resident #94 was cognitively intact. Oxygen use was not reflected on MDS. Review of the Care Plan dated 1/3/2026, revealed .RESPIRATORY .I have potential for respiratory distress related to weakness, impaired mobility, aging and potential medication side effects .Oxygen as ordered . Review of the Physician's Order dated 4/16/2026, revealed Oxygen at (2)L/min via nasal cannula continuous to maintain oxygen saturation of >90% every day and night shift. During an observation in Resident #94's room on 5/4/2026 at 11:09 AM and 3:15 PM, revealed Resident #94's oxygen was being administered at 3 L/min via nasal cannula. During an observation and interview in Resident #94's room on 5/5/2026 at 1:33 PM, LPN C was asked what Resident #94's oxygen rate was set at it. LPN C stated, .it is on 3 L/min and I believe it should be on 2 L/min. During an interview on 5/5/2026 at 2:48 PM, the DON was asked if the nurses should follow the physician's orders. The DON stated Yes. The DON was asked if the order was for oxygen to be at 2 L/min you would expect it to be. The DON stated On 2L/min.