

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Ahc Northside		STREET ADDRESS, CITY, STATE, ZIP CODE 202 East Mtcs 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46252</p> <p>Based on facility policy review, medical record review, signed written statements, and interview, the facility failed to report a staff to resident allegation of abuse to the State Survey Agency for 1 (Resident #6) of 8 sampled residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse Prohibition Plan, revised 10/24/2022, revealed, The facility has a zero-tolerance policy for abuse .physical abuse .is prohibited .The facility shall attempt to identify and shall investigate any reported violation or allegation of abuse .'Abuse' means the willful infliction of injury .or punishment with resulting physical harm, pain, or mental anguish .'Physical Abuse' includes .slapping . 'Alleged violation' is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another healthcare provider, or others but has not yet been investigated .The policy of this facility is that reports of abuse .are promptly and thoroughly investigated .The investigation shall begin immediately .The investigation and conclusion regarding all reported allegations/incidents of abuse shall be reported to the State Agency by way of the web-based Incident Reporting system (IRS) within 5 calendar days of the initial report of the abuse, incident, or allegations .are reported per Federal and State Regulations and Law .The facility shall ensure that alleged violations involving abuse .are reported to the Tennessee Department of Health, Health Care Facilities Division and Adult Protective Services, in accordance with requirements .All alleged violations are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse .The Administrator shall report the results of all investigations to the State Agency, within 5 working days of the allegation .All allegations, investigations, conclusions, corrective actions and electronic reports to the State Agency through the 'Incident Reporting System' (IRS) regarding abuse .</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses which included Acute kidney Failure with Tubular Necrosis, Heart Failure Unspecified, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, and Psychotic Disorder with Hallucinations. Resident #6 was discharged from the facility on 9/20/2023.</p> <p>Review of the Admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of twelve (12) which indicated moderate cognitive impairment.</p> <p>(continued on next page)</p>

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445373	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/18/2024
NAME OF PROVIDER OR SUPPLIER  Ahc Northside		STREET ADDRESS, CITY, STATE, ZIP CODE  202 East Mtcs 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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the General Nursing Note for Resident #6 dated 8/21/2024 at 10:50 AM revealed, Patient reported to CNA [Certified Nursing Assistant S] that the night shift [CNA Z] smacked her leg last night when changing her. [Resident #6] stated that she told [CNA Z] to stop that hurt and tech [CNA Z] smacked her leg again. Administrator notified by [Registered Nurse (RN) Y] immediately .</p> <p>Review of a signed written statement dated 8/21/2023, by Former Administrator revealed, On 8/21/23, [RN Y] and [CNA S], came to my office to report an occurrence .[Resident #6] advised them that a tech [CNA] overnight had slapped her leg twice .The patient was complaining of pain in her legs .The DON [Director of Nursing] assessed [Resident #6] and stated that the leg .was red, swollen, and warm to touch .[Resident #6] advised that it was painful, and that the tech [CNA] last night hurt it while doing patient care .it was very painful to touch and that it hurt when the tech turned her .</p> <p>Review of the signed written statement dated 8/21/2023, by the Former DON revealed, After [CNA S] reported to [RN Y] and [Former Administrator] .[Resident #6], was saying that the [CNA] overnight had slapped her leg twice, [Former DON] and Administrator went to speak with [Resident #6]. [Resident #6] was complaining of pain in her legs .On assessment .upper thigh is red, swollen, and warm to touch. [Resident #6] stated it was painful and that the [CNA] last night had hurt it .</p> <p>The facility was unable to provide documentation that this abuse allegation was reported to the State Agency.</p> <p>During an interview on 4/17/2024 at 10:30 AM, the Social Services Director (SSD) stated, I was not made aware of any allegation of abuse made by [Named Resident #6] .I usually assist in the reporting of abuse allegations.</p> <p>During a telephone interview on 4/17/2024 at 11:00 AM, RN Y stated, I went and talked with [Named Resident #6] .I went to the [Former Administrator]'s office and reported it immediately. My understanding was that the [Former Administrator] was going to start an investigation.</p> <p>During a telephone interview on 4/17/2023 at 11:30 AM, CNA S stated [Named Resident #6] had told me that the overnight [CNA Z] had slapped her leg twice when giving care. I reported it to [RN Y] and we both went to the [Former Administrator]'s office and reported what [Named Resident #6] had told me. I remember telling the [Former Administrator] who the night [CNA] was, and [Former Administrator] stated he would speak to [Named CNA Z] and [Named Resident #6] and find out what was going on .</p> <p>During an interview on 4/17/2024 at 12:20 PM, the Administrator stated, The documentation on the General Nursing Note for [Named Resident #6] was an allegation of staff to resident abuse and should have been reported to the State Agency on 8/21/2023 .</p>		