STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445378	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest at Blakeford	11 Burton Hills Blvd Nashville, TN 37215

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to submit an initial report of an allegation of staff-to-resident abuse to the state survey agency within two hours for 1 (Resident #31) of 1 resident reviewed for abuse. Specifically, CNA #18 failed to report an allegation of staff-to-resident abuse that occurred on 09/06/2024 until 09/13/2024. ^ The findings include: A facility policy titled, Abuse, Neglect, Misappropriation Protocol, revised 04/2025, revealed, 1. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing. An admission Record revealed the facility admitted Resident #31 on 10/26/2023. According to the admission Record, the resident had a medical history that included a diagnosis of unspecified severe dementia with agitation. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was short-tempered and easily annoyed half or more of the days over the last two weeks. Resident #31's Care Plan included an undated focus area that indicated the resident was at risk for behavior problems. Interventions directed staff to intervene as necessary to ensure safety of resident and others (initiated 08/08/2024). A handwritten witness statement by Certified Nursing Assistant (CNA) #18, dated 09/13/2024, revealed when CNAs #17 and #18 went to assist Resident #31 with a shower, the resident stated they did not want a shower. The witness statement indicated CNA #17 told Resident #31 that the resident was getting a shower and began to pull the resident's clothes off. The witness statement revealed Resident #31 hit CNA #17. The witness statement revealed CNA #17 hit Resident #31 back, pointed their finger at the resident, and told the resident, You don't hit me. An undated facility investigative document titled Note for Meeting 9/13/'24 [2024] [sic] with [Name of police officer] revealed, Administrator explained that the team was notified this morning (9/13) of an allegation of abuse that had happened last Friday (9/6) between a staff member and the resident [Resident #31]. An email from the state reporting agency, dated 09/13/2024 at 10:42 AM, indicated the initial submission of an allegation of physical abuse. A facility incident report, dated 09/17/2024 at 12:53 PM, indicated a witness stated that she asked the alleged perpetrator to assist with transferring Resident #31 for a shower. The incident report indicated during the process, Resident #31 became combative and hit the alleged perpetrator. The incident report indicated the alleged perpetrator slapped Resident #31 back, pointed their finger at the resident, and stated, Don't hit me. The incident report concluded, The investigation was conducted and has been concluded as not substantiated by view of the findings. During an interview on 03/04/2024 at 9:30 AM, CNA #18 stated that she was in Resident #31's room to get the resident ready for a bath when the resident became aggressive. CNA #18 stated that she was being assisted with the transfer of Resident #31 by CNA #17. CNA #18 stated that during the transfer Resident #31 hit CNA #17, and CNA #17 hit the resident back and stated, You don't hit me. CNA #18 stated that she reported the incident to the Administrator (ADM) a couple of days later because she worked overnight and no one was around during the night to receive the report. CNA #18 stated there was a nurse present on the unit, but the nurse was friends (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with CNA #17, and CNA #18 did not feel like anything would be done. CNA #18 stated that Resident #31 was slapped with an open hand but was unsure as to what part of the resident's body was hit. CNA #18 stated that Resident #31 was not injured. CNA #18 stated that if abuse was identified it was supposed to be reported. CNA #18 stated that she did not remember when she should have reported the incident. During an interview on 03/04/2026 at 9:59 AM, the ADM stated that on 09/13/2024 CNA #18 reported that, while providing care, CNA #18 witnessed CNA #17 being hit by Resident #31 and then CNA #17 hitting the resident back on 09/06//2024. The ADM stated she had a conversation with CNA #18 about the timeliness of reporting, and she was not sure why CNA #18 did not report the incident immediately per the policy. During an interview on 03/05/2026 at 8:49 AM, the Director of Nursing (DON) stated that her expectation was for staff to report abuse to her or the abuse coordinator as soon as it was identified, and that was how staff were trained. During an interview on 03/05/2026 at 9:23 AM, the ADM stated the facility process was that allegations of abuse were to be reported immediately, and that pertained to all staff. The ADM stated staff were trained in abuse at the time of hire and with routine facility training. The ADM stated that CNA #18 should have reported the incident as soon as it was identified.^