STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445406	A. Building B. Wing	06/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Community Care of Rutherford	901 County Farm Rd Murfreesboro, TN 37127

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on facility record review, interview, and facility document and policy review, the facility failed to protect a resident's right to be free from misappropriation of money and medications for 2 (Resident #6 and Resident #97) of 4 residents reviewed for misappropriation of property (Resident #6 and Resident #97)Findings included: A facility policy titled, Abuse Policy for [Facility Name], dated 06/02/2025, indicated, Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, nor visitors. Types: verbal, sexual, physical, mental, neglect, misappropriation of property, involuntary seclusion, injuries of unknown source. The attached document titled, Training on Abuse indicated, Misappropriation of patient property - the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a patient's belongings or money without the patients [sic] consent. 1. An admission Record revealed the facility admitted Resident #6 on 12/06/2024. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dementia in other diseases classified elsewhere (of unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), and cognitive communication deficit. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2026, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident cognitively intact. A facility document titled, Improvement Opportunity and Comment Form, signed by the Administrator (ADM) and dated 10/04/2025, revealed the resident discovered their wallet was missing from their lockbox after returning from a hospital stay. The missing contents included the resident's driver's license, Social Security card, approximately $30 to $40 in cash, and a diamond and mother of pearl ring. On 06/22/2026 at 1:39 PM, Resident #6 stated they went to the hospital for a few days and when they returned, they discovered the lockbox in their room had been broken into and their wallet and a ring were missing. On 06/25/2026 at 4:30 PM, the Administrator stated Resident #6 was sent to the hospital and when they returned, they reported they were unable to find their wallet and a ring. The Administrator interviewed the resident and assisted the resident in looking for the missing items. The resident had a lockbox in their room where they kept the items. The resident and the Administrator were unable to locate the items. The Administrator reported misappropriation to the State Agency and initiated an investigation. Interviews were conducted with the staff and residents. A resident in a neighboring room recalled hearing a strange sound on the night shift. The Administrator interviewed night shift staff and determined Resident #6 was assigned to Certified Nursing Assistant (CNA) #13's group. The Administrator interviewed CNA #13, and CNA #13 confessed to taking Resident #6's wallet, taking the money out of it, and hiding the wallet in the resident's room. The CNA told the Administrator where the wallet was hidden. The wallet was recovered with the resident's identification cards; however, no cash was in the wallet. The CNA denied taking the resident's ring. The Administrator called law enforcement and reported the theft, notified the resident and the ombudsman, and terminated CNA #13. The facility reimbursed the resident $50 for the money that was stolen from the wallet. The facility substantiated the investigation as misappropriation and reported to the State Agency within the regulatory timeframe. (continued on next page)

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

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Employee Counseling Statement revealed the facility terminated CNA #13 on 10/10/2025. On 06/27/2026 at 10:50 AM, the Director of Nursing (DON) stated the expectation was that staff would not borrow or take anything from a resident, theft would be reported immediately, and an investigation would be conducted. On 06/27/2026 at 10:17 AM, the Administrator stated the expectation was that staff would not steal from residents and they would follow their training on abuse, neglect, and misappropriation. 2. An admission Record revealed the facility admitted Resident #97 on 08/06/2024 and discharged the resident on 10/27/2025. According to the admission Record, the resident had a medical history that included diagnoses of Alzheimer's disease and dementia in other diseases classified elsewhere (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety), and other chronic pain. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2025, revealed Resident #97 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Resident #97's September 2025 Medication Administration Record (MAR) indicated the resident had a physician's order dated 08/07/2025 for oxycodone hydrochloride (HCl) oral tablet 10 milligrams (mg), to administer one tablet by mouth every four hours as needed for pain. An untitled facility document dated 09/01/2025 indicated Licensed Practical Nurse (LPN) #23 alerted the facility that the narcotic tracking sheet looked suspicious and that she was unable to locate Resident #97's oxycodone on the medication cart. On 06/27/2026 at 11:24 AM, LPN #23 stated the process for narcotic counts at the time of the incident involving Resident #97's oxycodone was that the outgoing nurse would conduct a narcotic count and the tell the incoming nurse what the count was. On the night of the incident, outgoing LPN #14 told incoming LPN #23 the narcotic count was 28. Resident #97 had been experiencing a decline and had an order for oxycodone. The resident requested their pain medication and LPN #14 was not able to find the resident's medication card. The nurse looked for the card and when it was not located, the nurse was able to access the medication in the Cubex and administer the requested medication to Resident #97. LPN #23 reviewed the narcotic count sheet and noticed the number 29 was scribbled out and the number 28 was written off to the side. LPN #23 notified the Administrator and wrote a statement. The pharmacist was contacted and they completed an audit of medications in the facility. The process was changed so that the incoming and outgoing nurses completed the narcotic count together. On 06/25/2026 at 3:51 PM, the Administrator stated on 09/01/2025, Resident #97 had requested an oxycodone for pain, and Licensed Practical Nurse (LPN) #23 was not able to locate the resident's medication card. The LPN searched the medication cart for the resident's medication card of oxycodone and did not locate the medication. LPN #23 reviewed the item tracking form for narcotics and discovered there was a discrepancy on the tracking form. The count on the form had been changed. The facility was able to access the medication in the Cubex and administer the oxycodone to the resident. An investigation was initiated. Staff were interviewed and it was determined the tracking form was changed on LPN #14's shift. LPN #14 was hired as agency staff and was not able to be reached for a statement. The Administrator notified the staffing agency of the discrepancy and asked the agency to have LPN #14 contact the Administrator. The Administrator checked LPN #14's license and found it had been surrendered on 04/29/2025 for medication diversion, and the LPN was not a licensed nurse at the time they were working in the facility. The facility called in a pharmacy to complete an audit of all medication carts. The Administrator provided copies of the facility's investigation and pharmacy medication audit. According to the documentation, the facility reported the incident to the state agency and local law enforcement timely.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, record review, and facility document and policy review, the facility failed to immediately implement protective measures following an allegation of staff-to-resident physical abuse and complete a timely and thorough investigation for 1 (Residents #94) of 6 residents sampled for abuse. Findings included: A facility policy titled, Abuse Policy for [Facility Name], dated 06/02/2025, indicated, Abuse: the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse will not be tolerated by anyone, including staff, patients, consultants, volunteers, family members or legal guardians, friends, nor visitors. 1. Any employee having direct or indirect knowledge of allegations of possible abuse, must report the event immediately. This facility will not retaliate against any resident, employee, or family member making good faith reports. The identity of the person reporting the allegation of abuse, [sic] will only be disclosed on a need to know basis. 2. When abuse is reported or observed, protect the resident first. Remove the resident from the source of suspected abusive behavior (intervene to keep them from harm). 3. Allegation [sic] of abuse must be immediately reported to Charge Nurse or Supervisor. Allegation can also be reported anonymously to [Name of a community based program to assist people in providing anonymous information about crimes] or our local Ombudsman. The policy also indicated, 6. Charge nurse is to conduct investigation immediately following the incidence to ensure resident will be protected from harm. 7. The results of all investigations will be completed within 5 days of the incident. Depending on the results of the investigation, all necessary corrective actions will be taken. The policy also indicated, D. Employee(s) suspected of potential harm to a resident or others will immediately be placed on administrative leave pending results of the investigation. An admission Record revealed the facility admitted Resident #94 on 12/20/2024. According to the admission Record, the resident had a medical history that included diagnoses of cognitive, social, or emotional deficit following other cerebrovascular disease, diabetes mellitus type 2, and acute kidney failure. A 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/24/2024, revealed Resident #94 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. A facility document titled Incident Reporting System [IRS], printed 03/03/2025, revealed an allegation of physical abuse involving a staff-to-resident interaction between Licensed Practical Nurse (LPN) #4 and Resident #94. The IRS record indicated facility staff became aware of the allegation on 12/24/2024, at approximately 6:36 PM, and reported the allegation on 12/24/2024 at 7:56 PM. The IRS record revealed Resident #94 alleged that staff used a silver lock to lock the resident's wheelchair and that LPN #4 pushed the resident's hand away when the resident attempted to grab the nurse during a transfer. Resident #94's Emergency Contact (EC) identified LPN #4 as the alleged perpetrator based on information provided by Resident #94. A graph, dated 01/24/2025, with resident names was included in the facility's investigation documents that indicated interviews were conducted with other residents regarding any abuse they may have witnessed. Four Head to Toe Skin Assessment[s], dated 01/24/2025, approximately 30 days after the alleged incident, were included in the facility's investigation. LPN #4's Timecard revealed she clocked in to work from 4:56 PM on 12/23/2024 until 7:44 AM the following morning. LPN #4's Timecard revealed she clocked in to work from 4:59 PM on 12/24/2024 until 6:08 AM the following morning. During an interview on 06/23/2026, at 1:12 PM, the Assistant Director of Nursing (ADON) stated that when an abuse allegation was reported, the facility's priorities were to ensure resident safety, obtain statements from involved staff, interview residents when appropriate, and complete skin assessments for residents with impaired cognition. The ADON stated that LPN #4 was identified as the alleged perpetrator in the incident involving Resident #94, and the facility's policy required any employee identified as an alleged perpetrator to be removed from duty pending completion of the investigation. During a telephone interview on 06/24/2026 at 9:02 AM, LPN #4 stated that on 12/24/2024 upon reporting to work, the Administrator informed her that Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#94 had alleged that physical abuse occurred during the early morning hours of 12/24/2024. LPN #4 stated she provided a written statement, spoke with detectives and Adult Protective Services (APS), and completed her work shift while the investigation remained ongoing. During an interview on 06/23/2026 at 1:31 PM, the Director of Nursing (DON) stated that the facility's abuse investigation process was consistent with the process described by the Assistant Director of Nursing (ADON). The DON could not explain why resident interviews and skin assessments related to the allegation involving Resident #94 were not completed until 01/24/2025. The DON stated that the delay was significant because timely interviews and skin assessments were necessary to identify injuries, determine whether abuse occurred, and help prevent further incidents. The DON added that LPN #4 was present in the facility on 12/24/2024 and should have been suspended in accordance with facility policy pending completion of the investigation. During an interview on 06/24/2026 at 9:35 AM, the Administrator, who also served as the Abuse Coordinator, stated that when an abuse allegation was reported, especially allegations of physical abuse, the alleged perpetrator should be immediately removed from the facility and not allowed to remain in the building during the investigation. The Administrator stated the investigation should begin immediately and include identifying witnesses, obtaining written staff statements, interviewing residents with BIMS scores of 8 or higher, conducting skin assessments for residents with BIMS scores below 8, and providing abuse education to staff. The Administrator stated the investigation should conclude by day five. The Administrator stated the facility failed to complete key investigative tasks within its expected time. During a follow-up interview on 06/27/2026 at 2:17 PM, the DON stated that the expectation was for LPN #4 to have been removed from resident care pending completion of the investigation. The DON stated the investigation should have been comprehensive and should have immediately included resident skin assessments, resident interviews, and staff in-service education. During a follow-up interview on 06/27/2026 at 3:27 PM, the Administrator stated that the facility did not follow its policy by allowing LPN #4 to continue working during the investigation. The Administrator also stated resident interviews, skin assessments, and staff in-service education should have been initiated and completed within the required five-day timeframe.