STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445419	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Overton County Health and Rehab Center	318 Bilbrey Street Livingston, TN 38570

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to document advance directives education and resident advance directive decisions in the medical record for 7 residents (Residents #3, #20, #24, #43, #56, #66, and #81) of 7 residents reviewed for advanced directives. The findings include: Review of the facility's policy titled, Advance Directives, revised 9/2022, revealed .The resident has the right to formulate an advanced directive .The facility defines the following .Advance care planning .Advance Directive .Living Will .Durable power of attorney for Healthcare .Prior to or upon admission of a resident, the social services director or designee inquires .about the existence of any written advanced directives .the resident or representative is provided with written information .information about whether or not the resident has executed an advanced directive is displayed prominently in the medical record . Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Mood Disorder, Psychotic Disorder with Hallucinations, Anxiety Disorder, Unspecified Dementia with Behavioral Disturbance, Chronic Kidney Disease, Convulsions, Spinal Stenosis, and Parkinson's Disease without Dyskinesia. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated severe cognitive impairment. Review of an admission Agreement dated 8/2/2010, revealed no written documentation of advance directive education for Resident #3 was discussed or provided to the resident's representative. Review of the medical record revealed no documentation for Resident #3's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Obstructive and Reflux Uropathy, Chronic Atrial Fibrillation, and Unsteadiness of Feet. (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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an admission MDS assessment dated [DATE], revealed Resident #20 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of an admission Agreement signed 2/28/2025, revealed no writen documentation of advanced directive education for Resident #20 was discussed or provided to the resident or resident's representative. Review of the medical record revealed no documentation for Resident #20's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. Review of the medical record revealed Resident #24 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Dementia, Depression, Psychotic Disorder, and Pain. Review of a quarterly MDS assessment dated [DATE], revealed Resident #24 scored a 12 on the BIMS assessment which indicated moderate cognitive impairment. Review of an admission Agreement signed 4/6/2024, revealed no written documentation of advance directive education for Resident #24 was discussed or provided to the resident or resident's representative. Review of the medical record revealed no documentation for Resident #24's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. Review of the medical record revealed Resident #43 was admitted to the facility on [DATE] with diagnoses including Stroke, Depression, Hypertension, and Difficulty Swallowing. Review of a quarterly MDS assessment dated [DATE], revealed Resident #43 scored an 11 on the BIMS assessment which indicated moderate cognitive impairment. Review of an admission Agreement signed 8/23/2024, revealed no written documentation of advance directive education for Resident #43 was discussed or provided to the resident or resident's representative. Review of the medical record revealed no documentation for Resident #43's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. Review of the medical record revealed Resident #56 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Type 2 Diabetes, Anxiety, and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #56 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Review of an admission Agreement signed 2/16/2023, revealed no written documentation of advance directive education for Resident #56 was discussed or provided to the resident or resident's representative. Review of the medical record revealed no documentation for Resident #56's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the medical record revealed resident #66 was admitted to the facility on [DATE], with readmission on [DATE], with diagnoses which included Malignant Neoplasm of Prostate, Secondary Malignant Neoplasm of Right Lung, Attention to Cystostomy, Gastrostomy, and Adult Failure to Thrive. Review of an end of Prospective Payment System stay MDS assessment dated [DATE], revealed Resident #66 scored an 8 on the BIMS assessment which indicated moderate cognitive impairment. Review of an admission Agreement signed 10/5/2023, revealed no written documentation of advance directive education for Resident #66 was discussed or provided to the resident's representative. Review of the medical record revealed no documentation for Resident #66's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. Review of the medical record revealed Resident #81 was admitted to the facility on [DATE] with diagnosis including Fracture of Lower End of Left Humerus, Generalized Anxiety Disorder, and Acute Kidney Disorder. Review of an admission MDS assessment dated [DATE], revealed Resident #81 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of an admission Agreement signed 4/14/2025, revealed no written documentation of advanced directive education for Resident #81 was discussed or provided to the resident or resident's representative. Review of the medical record revealed no documentation for Resident #81's decisions regarding advanced directives to include advanced care planning, living will, and power of attorney. During a record review and interview on 5/14/2025 at 9:00 AM, the Social Services Director (SSD) reviewed the signed admission Agreements and medical records for Residents #3, #20, #24, #43, #56, #66, and #81. The SSD stated there was no documentation in the medical records to indicate the residents had received and understood the advance directive education provided or information regarding the residents advance directive decisions. During further interview the SSD confirmed the facility failed to document advance directives education and resident advance directive decisions in the medical record for Residents #3, #20, #24, #43, #56, #66, and #81.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the Resident Assessment Instrument (RAI) Manual 3.0, medical record review, and interview the facility failed to accurately assess the discharge status for 1 resident (Resident #83) of 3 residents reviewed. The findings include: Review of the RAI Manual dated 10/2024, revealed .The RAI process has multiple regulatory requirements . the assessment accurately reflects the resident's status .A2105: Discharge Status .This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning . Review of the medical record revealed Resident #83 was admitted to the facility on [DATE] with diagnoses including Orthopedic Aftercare, Hypertension, Atrial Fibrillation, and Presence of Right Artificial Knee. Review of the Care Plan Report dated 1/27/2025 for Resident #83 revealed, .Focus .Potential for discharge to lower level of care .Goal .Resident/Responsible party/POA (Power of Attorney) will be aware of community resources prior to discharge . Review of the Discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #83 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #83's discharge status was coded as being discharged to .04. Short-Term General Hospital . Review of a Social Services progress note for Resident #83 dated 2/13/2025 at 11:10 AM revealed, .SW (Social Worker) spoke with [Named Home Health], and they have resident's referral and plan on admitting her to home health services in the morning . Review of a Discharge Summary note for Resident #83, dated 2/13/2025 at 5:05 PM, revealed, .Resident discharging home with daughter at this time . Review of the facility Transfer/Discharge report dated 2/13/2025 revealed Resident #83 was, .Discharging home with family and [Named Home Health] assisting with care . During an interview on 5/14/2025, at 10:28 AM, the Administrator confirmed Resident #83 was discharged home on 2/13/2025 and the MDS discharge asssessment was inaccurate. During an interview on 5/14/2025, at 10:40 AM, the MDS/Licensed Practical Nurse (LPN) stated Resident #83 was discharged home with home health on 2/13/2025. The MDS/LPN confirmed the resident's discharge MDS assessment dated [DATE] coded the resident as discharged to the hospital and was inaccurate.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 secure resident identifiable information during medication administration for 3 residents (Residents #16, #52, and #23) of 4 residents observed for medication administration. The findings include: Review of the facility's policy titled, Electronic Medical Records, revised 3/2014, revealed .Electronic records are an acceptable form of medical record management .Only authorized persons who have been issued a password and user ID [identification] code will be permitted to access .The facility will make reasonable efforts to limit the use or disclosure of protected health information .Our electronic medical records system has safeguards to prevent unauthorized access of electronic protected health information . Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Tourette's Disorder, Type 2 Diabetes, Mood Disorder, and Seizures. Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #16 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, Depression, Adjustment Disorder, and Pain. Review of an annual MDS assessment dated [DATE], revealed Resident #52 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including Adjustment Disorder, Schizophrenia, Anxiety, Bipolar Disorder, and Pain. Review of an end of Prospective Payment System stay MDS assessment dated [DATE], revealed Resident #23 scored a 5 on the BIMS assessment which indicated severe cognitive impairment. During an observation on 5/13/2025 at 10:01 AM, Licensed Practical Nurse (LPN) A pushed a medication cart to Resident #16 and Resident #52's room. The medication cart contained a laptop used for accessing electronic health care records and a narcotic record book which contained residents' narcotic prescription information. LPN A opened the Electronic Medication Record Administration tab on the laptop. LPN A left the medication cart and entered Resident #16's room to perform hand hygiene. LPN A left the medication cart with Resident #16's medical record information visible on the laptop screen. During further observation LPN A returned to the cart, opened the narcotic record book, prepared Resident #16's medications, partially closed the laptop screen, did not close the narcotic record book, and entered Resident #16's room for medication administration. The resident's medical record was visible on the laptop screen and the resident's narcotic prescription information was visible. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/13/2025 at 10:05 AM, LPN A returned to the medication cart. LPN A re-opened the laptop, prepared medications for Resident #52, closed the narcotic record book, partially closed the laptop screen, left the medication cart, and entered Resident #52's room for medication administration. Further observation revealed Resident #52's medical record was visible on the laptop screen. During an observation on 5/13/2025 at 10:07 AM, LPN A returned to the medication cart and pushed the medication cart to Resident #23's room. LPN A prepared Resident #23's medications, partially closed the laptop screen, left the medication cart, and entered Resident #23's room for medication administration. During an interview on 5/13/2025 at 10:10 AM, LPN A stated he was unaware he left Resident #16's medical record visible when he performed hand hygiene, and stated he was unaware he left Resident #16's narcotic prescription information visible during Resident #16's medication administration. LPN A also stated he was unaware he should have completely closed the laptop screen to prevent visibility and access to Residents #16, #52, and #23's health information. During further interview LPN A stated he was not aware and did not know how to use the electronic medical record system safeguards intended to protect residents' health information. During an interview on 5/13/2025 at 2:10 PM, the Director of Nursing (DON) stated it was her expectation for nurses to use the electronic medical record system safeguards, and expected nurses to secure resident medical record information. During further interview the DON confirmed the facility failed to secure residents medical information during medication administration for Residents #16, #52, and #23. During an interview on 5/13/2025 at 2:18 PM, the Administrator confirmed the facility failed to secure resident medical information during medication administration for Residents #16, #52, and #23.