STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445427	A. Building B. Wing	01/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Bethesda	444 One Eleven Place Cookeville, TN 38501

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to execute an orderly discharge for one resident (Resident #1) of 4 residents sampled for admission, transfers, or discharges. The facility failure occurred when it referred the discharged resident to out of network providers for follow-up home health care, failed to schedule follow up appointments with the primary care physician of record, and failed to send prescriptions to the pharmacy of record at the time of discharge.The findings include:Review of the facility policy, Transfer or Discharge, copyright date 2001, revealed, .When the facility transfers or discharges a resident, the following information is communicated to the receiving healthcare institution or provider .Disposition of Medications .receiving facility's services that are available to meet .needs .Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Aphasia Following Cerebral Infarction, Type 2 Diabetes with Neuropathy, Unspecified Dementia, Depression, Duodenal Ulcer Unspecified, and Fibromyalgia.Review of the discharge Minimum Data Set (MDS), dated [DATE], revealed Resident #1 scored 15/15 on the brief interview of mental status examination which indicated Resident #1 was cognitively intact. Resident #1 was free of behaviors or cognitive impairment and required minimal to moderate assistance of one person for activities of daily living.Review of discharge summary for Resident #1, dated 12/23/2025, revealed the name of the pharmacy where prescriptions were to have been sent at the time of discharge. The line for the pharmacy provider's fax number was blank. The document stated the prescription orders were conveyed to the pharmacy by fax. Continued review showed Resident #1 was referred by the facility to home health services with a local agency for follow-up physical therapy and nursing care with the provider named. Continued review revealed no follow-up care with Resident #1's primary physician was scheduled at the time of discharge. The document was signed by the discharging nurse and Resident #1.Review of pharmacy orders electronically transferred to the pharmacy provider by the facility revealed the facility did not transfer orders for discharge medications until 12/30/2025. (7 days after Resident #1 discharged from the facility). There was no evidence in records reviewed that pharmacy orders were transmitted to the pharmacy at the time of discharge as documented on the discharge summary.During a telephone interview on 01/14/2026 at 11:21 AM, the home health service director (HSD) reported she did receive a referral for Resident #1 for PT (Physical Therapy), OT (Occupational Therapy) and nursing services on 12/23/2025, but Resident #1 was not eligible due to the company was out of network for Resident #1's insurance. HSD reported she called the facility on 12/23/2025 and reported to staff that Resident #1 would not be admitted but never received a return call from the facility. During an interview on 1/20/2026 at 2:30 PM, the Director of Nursing, (DON) confirmed the facility failed to refer Resident #1 to an in-network home care provider at discharge. The DON confirmed, for unknown reasons, calls from the home care provider to that effect had not been conveyed up the chain of command to (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the social worker or facility leadership by floor staff and as a result, the facility failed to provide an effective discharge plan for post discharge wound care and therapy services ordered to Resident #1. The DON confirmed multiple personnel responsible for discharge planning and care coordination were all off duty on 12/24/2025 and 12/25/2025 or on vacations over the holidays until the end of the year, and no designated person to fulfill their responsibilities was in place during their absence. The DON further confirmed the facility could not provide any information indicative it had faxed prescriptions to Resident #1's pharmacy at the time of discharge (as documented on the discharge summary). The DON confirmed prescriptions were electronically transferred to the pharmacy on 12/30/2025 (7 days after Resident #1's discharge) and that occurred after Resident #1's family member called the facility to complain that no prescriptions were provided for the Resident on 12/23/2025, which she was not made aware of until 1/3/26 upon her return to work.During an interview on 1/20/2026 at 4:30 PM in the conference room, the Social Service Director (SSD) confirmed she coordinated the discharge for Resident #1. SSD confirmed Resident #1 was referred to the home care provider with no follow-up. SSD stated she did not set up any follow up appointments with the primary care provider because Resident #1 informed her at discharge she would do it herself. SSD stated she did not coordinate discharge prescription transfers, which were managed by the unit manager who was a nurse. The SSD further stated she was unaware that the home care service to which Resident #1 was referred on 12/23/2025, was out of network for the resident. The SSD also confirmed she had previously reported she had not received telephone messages left to the facility from the homecare provider to inform her it was out of network and wouldn't admit Resident #1 on 12/23/2025 because by that time, she was off work for Christmas break and staff who received messages from the home care provider had not relayed them to her.During an interview on 1/21/2026 at 3:50 PM, the facility Administrator confirmed Resident #1's discharge was not executed in accordance with facility expectations as outlined in policies and procedures. The Administrator confirmed the facility failed to ensure the home health services referred were available to Resident #1 and failed to ensure that medication orders were received by the pharmacy timely. The facility failed to ensure follow-up appointments with the primary care provider were verified prior to Resident #1's discharge. The Administrator confirmed due to absences of facility personnel over the holiday, who were responsible for discharge planning and follow-up care with no backup persons available, communications with the home care service to whom Resident #1 was referred were interrupted, and because the facility failed to ensure alternate personnel were in place to maintain lines of communication with outpatient providers and to coordinate discharge care at time of Resident #1's discharge, the facility failed to provide a safe or effective discharge for Resident #1.