STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445435	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodbury Health and Rehabilitation Center	119 West High Street Woodbury, TN 37190

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, hospital document review, observation, and interview, the facility failed to implement a care plan intervention after a fall for 1 resident (Resident #7) of 3 residents reviewed for accidents. Resident #7 sustained a fall without injury on 5/15/2025 with a care plan intervention of non-skid strips on the floor at the bedside. The facility failed to implement the care plan intervention of non-skid strips on the floor at the bedside after the fall on 5/15/2025, and on 4/12/2026, Resident #7 sustained a second fall which resulted in a left hip fracture. The facility's non-compliance resulted in actual Harm to Resident #7.The findings include: Review of the facility policy titled, Falls and Incident Management Policy, undated, .Charge Nurse will put an immediate intervention in place .The IDT [Interdisciplinary Team] will review and select an intervention to prevent future falls from occurring .Place the intervention on the Falls Care Plan . Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Lack of Coordination, and Anxiety Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #7 was independent with all aspects of care. Review of a Nurses' Note for Resident #7 dated 5/15/2025, revealed .Resident [Resident #7] was yelling help from her room .Upon entering the room resident [Resident #7] was found sitting on the floor in front of her chair .stated she was trying to get to the bathroom and slipped and fell . Review of the Incident Report for Resident #7 dated 5/15/2025, revealed .Resident [Resident #7] slipped .Attempting self-transfer .alone and unattended .socks .poor vision .Root Cause .Footwear . Review of the root cause analysis for Resident #7 dated 5/15/2025, revealed a new intervention .Nonskid strips to exiting side of bed . Review of a comprehensive care plan dated 5/15/2025, revealed Resident #7 had a .falls [fall] r/t [related to] confusion, deconditioning, incontinence, and vision and hearing problems .5/15/2025 x ray of coccyx with negative results; Nonskid strips to exiting side of bed . Review of a Radiology Report for Resident #7 dated 5/16/2025, revealed .There is no fracture or periosteal reaction [bone looks normal and undisturbed] . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #7 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Resident #7 was independent with all aspects of care. Review of a comprehensive care plan dated 3/3/2026, revealed Resident #7 had a .falls [fall] r/t [related to] confusion, deconditioning, incontinence, and vision and hearing problems .4/12/2026 ER [Emergency Room] for eval [Evaluation] with fracture, staff education to not place belongings out of field of vision . Review of a Nurses' Note for Resident #7 dated 4/12/2026, revealed .Resident was heard hollering, CNA [Certified Nurse Assistant] entered room to check on resident finding her in the floor .Resident sitting beside her bed in front of her chair . Review of the Incident Report for Resident #7 dated 4/12/2026, revealed .Resident heard hollering, CNA entered room to check on resident finding her in the floor. Resident sitting beside her bed in front of her chair . Review of the root cause analysis for Resident #7 dated 4/12/2026, revealed .ED (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	[Emergency Department] to eval. Staff education to not place belongings out of field of vision . There was no documentation in the root cause analysis regarding the facility's failure to implement the care plan intervention of non-skid strips to the bedside. Review of a Radiology Report for Resident #7 dated 4/12/2026, revealed .left intertrochanteric fracture . Review of the Operative/Procedure Note for Resident #7 dated 4/15/2026, revealed .Left displaced intertrochanteric fracture .Procedure: Internal fixation left hip . During an interview on 4/20/2026 at 11:52 AM, Resident #7 stated she fell on 4/13/2026 and broke her left hip. During an observation in Resident #7's room on 4/21/2026 at 2:30 PM, revealed no nonskid strips at bedside (intervention after a fall on 5/15/2025). During an observation and interview in Resident #7's room with Licensed Practical Nurse (LPN) A on 4/21/2026 at 3:00 PM, revealed nonskid strips were not in place at the bedside. LPN A confirmed the nonskid strips were not in place. During an observation and interview in Resident #7's room with the Director of Nursing (DON) on 4/21/2025 at 3:13 PM, revealed nonskid strips were not in place at the bedside. The DON stated Resident #7 had a fall on 5/15/2025 and the intervention was for nonskid strips to be placed at the bedside. The DON confirmed Resident #7 had a second fall on 4/13/2026, sustained a hip fracture, and the nonskid strips were not in place at the time of the fall. During an observation and interview in Resident #7's room with the Administrator (ADM) on 4/21/2026 at 3:16 PM, revealed nonskid strips were not in place at the bedside. The ADM confirmed the nonskid strips were not in place. During an interview on 4/22/2026 at 9:10 AM, CNA A stated she cared for Resident #7 routinely, the resident had a fall about a week ago (unsure of the exact date) and fractured her left hip. CNA A also stated she had not observed nonskid strips at the bedside until today (4/22/2026). During an interview on 4/22/2026 at 9:15 AM, LPN A stated she cared for Resident #7 routinely and the nonskid strips at the bedside were placed yesterday (4/21/2026). During an interview on 4/22/2026 at 9:25 AM, the Regional Director (RD) stated the nonskid strips were placed at Resident #7's bedside after they (the facility) were informed on 4/21/2026 the strips were not in place.