STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445460	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Vanco	813 S Dickerson Rd Goodlettsville, TN 37072

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on policy review, interview, and observation, the facility failed to provide reasonable accommodations of needs for water temperature when bathing for 3 of 14 sampled residents (Resident #24, #28, and #64) interviewed for activities of daily living. The findings include: 1. Review of the facility policy titled, Resident Rights, dated 8/2009, revealed .Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of the facility . Review of the Rules of the Tennessee Health Facilities Commission dated July 2022, revealed .Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities shall be between 105 [degrees] F [Fahrenheit] and 115 F . 2. Review of the medical record revealed Resident #24 admitted to the facility on [DATE], with diagnoses which included Atherosclerotic Heart Disease, Cardiomyopathy, and Diabetes Mellitus type 2. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #24 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate impairment. During an observation and interview on 2/24/2025 at 12:20 PM revealed Resident #24's bathroom water was turned to hot and running. Resident #24 was asked why the bathroom water was running and she stated, . they [referring to the CNAs] trying to get the water hot . Observation in Resident #24's bathroom on 2/25/2025 at 8:37 AM revealed a hot water temperature of 78 degrees. 3. Review of the medical record revealed Resident #28 admitted to the facility on [DATE], with diagnoses which included Hypertensive Heart Disease, Anemia, Hyperlipidemia, and Atherosclerotic Heart Disease. Review of the Quarterly MDS dated [DATE], revealed Resident #28 had a BIMS score of 15, which indicated intact cognitive abilities. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/24/25 at 12:32 PM, Resident #28 stated, .I get a bed bath 2 or 3 times a week .the water is cold .the CNAs [Certified Nursing Assistants] will let it run forever trying to get it hot . During an interview on 2/24/2025 at 12:47 AM, Certified Nursing Assistant (CNA) P was asked why the hot water was running in 2 rooms. CNA P stated, .I am trying to get the hot water warm enough to give a couple of bed baths .it is like this every day .it takes forever and sometimes it never gets hot enough . 4. Review of the medical record revealed Resident #64 was admitted on [DATE], with diagnoses which included Cerebral Infarction, Depression, Hemiplegia affecting left nondominant side, and Essential Hypertension. Review of the Annual MDS dated [DATE], revealed Resident #64 had a BIMS score of 15, which indicated intact cognitive abilities. During an interview on 2/24/2025 at 11:53 AM, Resident #64 stated, .I get a bed bath once per day .no hot water, wash us down in cold water . Observation in Resident #64's bathroom on 2/25/2025 at 8:17 AM revealed a hot water temperature of 97 degrees. 5. During an interview on 2/25/2025 at 9:00 AM, the Maintenance Director was asked why the hot water on the 100 and 200 hall was not up to temperature and why CNAs are having to turn on the water in the bathrooms prior to breakfast so it will be warm enough to perform a bed bath. The Maintenance Director stated, .we have insta hots a hot water on demand system on the 100 and 200 hall .until a high demand is needed the water can't heat up .they need to turn on the water in three bathrooms before the water will heat to the right temperature . During an interview on 2/27/2025 at 8:00 am, the Social Service Director stated, .we have had residents complain about the water being cold and that is why they don't want to take a shower .I know the Maintenance director knew about it . During an interview on 2/27/2025 at 5:19 PM, the Administrator was asked about the hot water system on the 100/200 hall and if staff and residents should be waiting on hot water every day. The Administrator stated, .they should not have to wait on hot water .you have to get the water going on the hall before you can get the hot water . The Administrator was asked if staff should have to turn the hot water on in three bathrooms before the hall has hot water and what would the residents do if they wanted to wash their hands in the bathroom. The Administrator stated, .I am not saying we should have to do that .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on the facility policy review, medical record review, observation and interview the facility failed to provide privacy for 1 of 28 (Resident #28) sampled residents reviewed. The findings include: 1. Review of the facility policy titled, Resident Rights, dated 8/2009, revealed .Employees shall treat all residents with kindness, respect, and dignity .These rights include the resident's right to .Privacy and confidentiality .Visit and be visited by others from outside the facility .Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity . 2. Review of the medical record revealed Resident #28 admitted to the facility on [DATE], with diagnoses which included Hypertensive Heart Disease, Anemia, Hyperlipidemia, and Atherosclerotic Heart Disease.? Review of the Quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #28 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognitive abilities.?? During an observation and interview on 2/25/2025 at 2:35 PM, Certified Nursing Assistant (CNA) BB and CNA CC entered Resident #28's room without knocking or asking to come into her room while the surveyor was performing an interview. After the two CNAs entered the room and saw the Surveyor, CNA BB asked if they could come in after already entering the closed door. Resident #28 had just been asked by the surveyor if she was treated with respect and dignity at the facility. After the 2 CNAs entered the room without knocking Resident #28 stated, .Well they didn't that time . and rolled her eyes. During an interview on 2/27/25 at 5:07 PM, the Administrator was asked what he would expect the CNAs to do before entering a resident room. He stated, CNAs should knock before entering a room.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38439 Based on policy review, medical record review, facility investigation, observation, and interview, the facility failed to ensure an allegation of abuse was reported for 1 of 6 (Resident #27) sampled residents reviewed for allegations of abuse and neglect. The findings include: 1. Review of the facility's undated policy titled, Abuse, Neglect, Exploitation, and Misappropriation Prevention Program, revealed Residents have the right to be free from abuse, neglect and misappropriation of resident property and exploitation. This includes but not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraints not required to treat the resident's symptoms .investigate and report any allegations within timeframes required by federal requirements . 2. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Muscle Weakness, Difficulty Walking, Hemiplegia and Hemiparesis, Optic Atrophy Left Eye, Dementia, Attention and Concentration Deficit, Memory Deficit, and Fracture (broken bone) of Upper Humerus (upper arm). Review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #27 had a Brief Interview for Mental Status score of 6, indicating severe cognitive impairment, and required supervision for Activities of daily living (ADLs). Review of a facility's Clinical Note dated 8/17/2024, revealed At approximately 715pm [7:15 pm] resident [#27's] family said that resident told them that someone took him by the arm and 'spun me around' .He was upset about temperature in room issue with roommate. Resident was sitting in front of air conditioner unit and seemed to be guarding it . Review of a facility's Clinical Note dated 8/17/2024, revealed Reported incident to DON [Director of Nursing] for follow up. Resident's sister made aware that DON notified. Review of a facility's Clinical Note dated 8/18/2024, revealed Sister came to nursing station and said she had spoken to DON. She said that resident complained to her about shoulder pain. When this nurse questioned resident about pain later he denied pain. Asked to look at resident's shoulder and resident would not allow. Review of the facility's Grievance Record dated 8/19/2024, confirmed Resident #27 told his daughter that someone took him by arm and moved him around in his wheelchair in a rough way on 8/17/2024 as a result of Resident #27's obsession with controlling the thermostat in the room. The allegation of abuse was not reported on 8/17/2024 when Resident #27 reported it to his daughter. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #27's interview and statement dated 8/19/2024, revealed Did someone take your hand and turn your around in our wheelchair .No response .Can you tell me who it was that took your hand .I don't know her name .Can you tell me if she worked day shift or night shift .Day time .was she turning you around in our w/c .No response .Was she trying to reposition you in the W/C .no response .Would you be able to recognize her i you saw her .Yes .I told resident I would bring in several staff to let him identify who it was. After bringing in 2 staff members, he did not identify them, he then recognized the third staff member, [Named CNA EE] and pointed to her saying it was her . Review of the written statement from CNA EE dated 8/18/2024, revealed I answered the room light of . Resident #16 [On 8/17/2024] complained about the heat and asked to have the AC turned on. I went to turn the AC on and then went back to passing trays, not even 2 minutes later, did Resident #16 have the room light on again, stating Resident #27 cut off the AC. I went to turn on the AC again at which point Resident #27 started to yell and point his finger telling me to get out of his room, it's possible that his hand hit my body during this time .signed by CNA EE. During an interview on 2/25/2025 10:05 AM, Sister #2 of Resident #27 confirmed that Resident #27 had called her sister (Sister #1) and she heard loud noise in Resident #27's room and she called her and they both went to visit Resident #27 at shift change on Saturday 8/17/2024. Sister #2 confirmed that Resident #27 told them that someone had grabbed his arm and twirled him around in his wheelchair. Sister #2 confirmed that she asked night shift about it and no one knew anything about it but Resident #27 just kept asking for them to take him home and complaining that his arm was hurting and was numb. Sister #2 confirmed that she told Charge Nurse and the next day they found out it was a CNA [First Name CNA EE]. Sister #2 confirmed that the x-ray showed that the right arm was fractured. Sister #2 confirmed that the Administrator was out of town over the weekend but the charge nurse called the Director of Nursing and told her what had happened. Sister #2 confirmed that she was the one who called NP HH on Saturday when she was told by Resident #27 and told her what Resident #27 had told her and Sister #1. During an interview on 2/25/2025 at 10:38AM, the Administrator confirmed the CNA was CNA EE and was terminated due to other unrelated issues. The Administrator confirmed a timeline of events was in the facility's investigation that showed when the incident occurred. The Administrator confirmed that family reported the incident to staff on Saturday 8/17/2024 and that staff was educated on properly repositioning of residents as an intervention to the incident and the injury was not an allegation of abuse or an injury of unknown and was not reported to state agencies. The facility failed to report allegations of abuse on 8/17/2024 when Resident #27 reported that a staff member spun him around by his arm in his wheelchair that resulted of a fractured right arm.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44724 Based on facility policy review, medical record review, and interview the facility failed to revise comprehensive care plans for 2 of 28 (Resident #3 and #64) sample residents reviewed. The Findings include: 1. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, dated 3/2022 revealed, . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . 2. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnosis which included Chronic Obstructive Pulmonary Disease, Anemia, Hypothyroidism, Anxiety Disorder, and Hyperkalemia. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #3 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. Review of the care plan dated 2/8/2025 revealed Resident #3 was not care planned for Do Not Resuscitate (DNR) status. During an interview on 2/26/2025 at 8:47 AM the Director of Nursing (DON) was asked to Review Resident #3's POST (Physician Order for Scope of Treatment)?form and confirmed the code status was DNR. The DON was asked to review Resident #3's physician orders and care plan. The DON stated, .I don't see an order for DNR, and she doesn't have a care plan for DNR . Review of the Order Summary Report revealed an order for DNR added on 2/26/2025 at 11:37 AM after the interview with the DON. 3. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE], with diagnosis which included Cerebral Infarction and Hemiplegia affecting left nondominant side, Review of the Care Plan Report dated 10/2/2023 - Present revealed a problem for self-care deficit and requires assistance with ADLs (Activities of Daily Living) with no interventions related to the use of the immobilizer brace or person-centered transfer interventions with her recent fracture to the left leg. Review of the Radiology Report dated 2/7/2025 revealed, .FEMUR MIN .2 VIEWS, LEFT Results: Acute nondisplaced supracondylar distal femoral fracture . During an interview on 2/24/25 at 11:54 AM, Resident #64 stated, .I broke my leg three Mondays ago, the Certified Nursing Assistant [CNA] was transferring me. I have a brace on my left leg now to help it heal . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/2025 at 3:20 PM, the Rehab Director stated, .[Named Resident #64] has always been difficult to transfer requiring substantial assistance of 1 person to stand and pivot with the resident .we are suppose [supposed] to evaluate a resident and make recommendations, provide education with transfers .we have not evaluated her since 7/2024 . During an interview on 2/27/2025 at 11:15 AM, the DON confirmed the care plan does not reflect her recent fracture and how the resident should be transferred or repositioned.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services related to activities of daily living (ADLs) for 1 of 3 (Resident #29) sampled residents for ADLs. The findings include: 1. Review of the facility's policy titled, Activities of Daily Living (ADL), Supporting, dated 2001, revealed . Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs) .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .Care and services to prevent and/or minimize functional decline will include appropriate pain management, as well as treatment for depression and symptoms of depression .Interventions to improve or minimize a resident's functional abilities will be .will be monitored, evaluated and revised as appropriate . Review of the facility policy titled, Resident Rights, dated 2001, revealed .Employees shall treat all residents with kindness, respect, and dignity . 2. Review of the medical record revealed Resident #29 was admitted to the facility on [DATE], with diagnoses including Diabetes, Hypertension, and Vitamin D Deficiency, and Cognitive Communication Deficit. Review of a quarterly Minimum Data Set assessment dated [DATE], revealed Resident #29 had no behaviors, a Brief Interview for Mental Status score of 11, which indicated Resident #29 had moderately impaired cognition. Further review revealed the resident required clean up assistance from staff for toileting hygiene and personal hygiene and was occasionally incontinent of urine and always incontinent of bowel. Review of the care plan dated 2/21/2025, revealed .at risk for ADL/mobility decline and requires assistance related to disease progression .Provide the resident with AM [morning] and PM [evening] care [oral and grooming] daily and assist the resident as needed for completion of task .Toileting hygiene and incontinent care daily and as needed . Observation on 2/24/2025 at 11:16 AM and 12:13 PM, revealed Resident #29 in bed, appeared to be sleep, in a sleep shirt and brief. Observation on 2/24/2025 at 4:21 PM, revealed Resident #29 was in bed laying on her left side wearing an incontinent brief soiled with urine. During an interview on 2/24/2025 at 4:29 PM, CNA P was asked about Resident #29. CNA P stated, . not getting up stated she told me to get the hell out of her room . everyday resident very seldom up .3 to 4 days per week will not let you do anything .have not reported to nurse today . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 2/25/2025 at 1:52 PM, revealed Resident #29 in room sitting on side of bed. Resident #29 had facial hair over her lip. Resident #29 was asked does she want the facial hair off or does she want to keep the facial hair. Resident #29 stated, Want it off. Resident #29 confirmed she needs the assistance from staff for removal of her facial hair. During an interview on 2/27/2025 at 8:59 AM, the Director of Nurses confirmed residents who want their facial hair removed should have help from staff to get it removed. The DON was asked if a resident continues to refuse incontinent care what should staff do. The DON confirmed the C NA should notify the charge nurse, document the refusal, and staff should use a different approach. The DON confirmed if redirection and explaining the consequences of the refusal does not work, staff should try to find out why the resident refuses. During an observation and interview 2/27/2025 at 9:11 AM, revealed Resident #29 continued to have a mustache. Resident #29 confirmed she would like the mustache removed and confirmed staff had not offered to remove her facial hair. The DON confirmed the staff are expected to recognize the need to remove the resident's facial hair and offer to remove.

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F 0689 Level of Harm - Minimal harm or potential for 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** 38439 Based on facility policy review, medical record review, facility investigation, and interview, the facility failed to provide adequate supervision and assistance to prevent an elopement from the facility for 1 of 3 residents (Resident #80) reviewed for wandering. The facility failed to provide adequate supervision and assistive devices when Resident #1 eloped from the facility on 10/29/2024 at 9:40 AM, resulting in a fall with minor injuries. The Findings Include: 1. Review of the facility policy titled, Elopement and Wandering Patients, revised 2/5/2024, .This facility ensures that residents who exhibit wandering behavior and/or are at risk for elopement receive adequate supervision to prevent accidents and receive care in accordance with their person-centered plan of care addressing the unique factors contributing to wandering or elopement risk .Residents shall be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care plan team . 2. Review of medical record revealed Resident #80 was admitted to the facility on [DATE], with diagnoses including Traumatic hemorrhage of left cerebrum (a collection of blood in the brain that occurs after a head injury) without loss of consciousness, subsequent encounter, Traumatic subdural hemorrhage (at type of bleeding near your brain that can happen after a head injury) without loss of consciousness, subsequent encounter, Malignant neoplasm (lung cancer) of upper lobe, right bronchus or lung, Alcohol use, Chronic Obstructive Pulmonary Disease (a chronic lung condition that makes it difficult to breathe), Chronic Atrial Fibrillation (an irregular heartbeat), Tobacco use, anxiety disorder, aphasia (a disorder that affects how you communicate), other Chronic Pain, Essential (Primary) Hypertension (High Blood Pressure), Depression, and Muscle Weakness (Generalized). Review of the physician orders dated 10/21/2024, for Resident #80 revealed, MD orders for Buspirone 7.5 mg (milligram) twice a day for Anxiety, Lexapro 20 mg once a day for depression, Hydralazine 23 mg every 8 hours for high blood pressure, Losartan 25 mg one time a day for high blood pressure, Metoprolol 25 mg twice a day for high blood pressure, Nicotine Patch one time daily, Trazodone 100 mg tablet one at bedtime for depression, Clonazepam 1 mg tablet three times a day for anxiety, gabapentin 300 mg capsule three times a day for chronic pain, Behavior Monitoring three times a day, and Psychotropic medication monitoring two times a day. Review of the Fall Risk assessment dated [DATE] for Resident #80 revealed falls history of a single fall in the past 90 days with a fall risk total score of 8 with a risk scale of 0-10 = Low. Review of the Elopement Risk assessment dated [DATE], revealed Resident #80 could ambulate independently, was at risk for leaving the facility to satisfy addiction which indicated Resident #80 was at high risk for elopement. Review of the admission baseline care plan dated 10/22/2024, revealed, a problem for at risk for elopement. A goal of resident will maintain a safe environment with no interventions noted on the care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nurse progress note dated on 10/22/2024 at 11:53 AM, revealed, . Resident [Resident #80] found to have wandered in another female patient room. Resident easily directed out of room, but asking what room her sister is in. Resident informed her sister is not at this facility and resident proceeds to ask .tell me what happened to her. Informed her that her sister has never been at this facility that this is not the hospital she is at a skilled nursing facility. Resident [Resident #80] proceeds to get angry and yell at this nurse telling her she doesn't know what she is talking about and started towards her room mumbling under her breath . signed by LPN OO. Review of the nurse progress note dated 10/23/2024 at 6:09 AM, revealed . Resident [Resident #80] wandering halls during the evening shouting obscenities and taunting staff and other residents. Walked into her restroom and urinated in the middle of the floor in front of me. Pt stated she's been here 6 months and been treated poorly the whole time, educated pt that she only just arrived. Redirection unsuccessful, making roommate and staff uncomfortable with her [NAME]. Very confused. Restless and agitated until receiving pharmacy delivery and was given her medications then slept most of the night . signed by RN PP. Review of Physical Therapy Progress Report dated 10/23/2024 through 10/28/2024 for Resident #80 revealed, .Functional Skills Assessment .Walk 10 feet = Partial/Moderate Assist .Walk 50 feet with 2 turns = Partial/Moderate Assessment .Walk 150 feet = Partial/Moderate Assist .Mobility function Score .(Range 0-12, 12 Highest function) = 8 .by Physical Therapist (PT) QQ on 10/28/2024 at 9:12 AM. Review of the nurse progress notes for Resident #80 dated 10/26/2024 at 10:30 AM, 10/26/2024 at 3:20 PM, 10/26/2024 at 4:03 PM, revealed documentation of wandering behaviors. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 5, which indicated Resident #80 was severely cognitive impaired. Continued review revealed Resident #80 exhibited wandering behaviors that placed the resident at significant risk of getting to a potentially dangerous place (outside of the facility), and significantly intruded on the privacy or activities of others had occurred 1 to 3 days of the assessment look back period. Review of the Care Plan updated 10/29/2024, for Resident #80 revealed, . At Risk For Falls related to the following potential causative factors: unsteadiness of gait and balance when on feet; generalized muscle weakness; altered mental status with a very poor safety awareness; adverse effects from psychotropic medications . [Resident #80] will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day review period . 10/29 FALL WITH INJURY . Confusion, alteration in thought process related to [Resident #80] had a low BIMS score and a Slums test .recent had a falling incident which resident sustained a traumatic hemorrhage of the left cerebrum .[Resident #80] has exhibited Wandering and exit seeking Behavior .resident is very difficult to be redirected and will become agitated and verbally inappropriate .update 10/29/24 resident wandered out of the facility . (continued on next page)

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	445460	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Vanco	813 S Dickerson Rd Goodlettsville, TN 37072

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the [Named] Medical Center Emergency Provider Report dated 10/29/2024 at 11:57 AM, for [Resident #80] revealed, .History of Present Illness: History was obtained from the patient and EMS [Emergency Medical Services]. [Resident #80] is a 65 -year-old female presenting to the ED by EMS secondary to fall. EMS reports that she fell on a sidewalk and went into the courthouse to ask them for help. They noted a laceration to her left great toe and an abrasion to her right arm. Initially she did not want to be transported but they realized the patient was acting confused at times. She was alert oriented X 3 but some things that she was saying was not making sense. She told them that she was assaulted 6-8 weeks ago. On arrival here the patient has no complaints but tells me that she was assaulted 6-8 weeks ago and was in the hospital for several weeks. She reports when she left she was sent to a place in Louisville that is for people with OCD [Obsessive-Compulsive Disorder]. EMS did note that her blood pressure was 80 systolic upon their arrival .Review of Systems .Abrasion [a scrape on your skin] noted to posterior [back of] right arm with no active bleeding, small superficial laceration [a cut close to the surface of the body] noted to left great [big] toe .Summary of visit: [AGE] year-old female presenting to the ED secondary to confusion and fall. I did review the patient prior discharge summary. It reported she had a traumatic intracranial hemorrhage with expressive aphasia. She also has a history of substance abuse and alcohol abuse. We will obtain lab work to include a repeat head CT . 46252

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46047 Based on policy review, medical record review, and interview the facility failed to ensure a resident's medication regimen was free of unnecessary medications when the facility failed to ensure monitoring related to the use of an anticoagulant (blood thinner) for 1 of 5 residents (Resident #39) sampled for unnecessary meds. The findings include: 1. Review of the facility's policy titled, Anticoagulation - Clinical Protocol, dated 2/2014, revealed .The staff and physician will identify and address potential complications .The staff and physician will monitor for possible complications . 2. Review of the medical record revealed Resident # 39 was admitted to the facility on [DATE], with diagnoses including Hypertension, History of Thrombosis and Embolism, and Paralytic Gait. Review of the significant change Minimum Date Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated Resident #39 had intact cognition, received antidepressant, antipsychotic, anticonvulsant, diuretic, and anticoagulant medications. Review of the Physicians Order dated 11/6/2024, revealed Eliquis [an anticoagulant-blood thinner] Tab 2.5 MG [milligrams] Give 1 tablet orally two times a day for hx [history] of embolism. Review of a Medication Administration Record dated 12/2024, 1/2025, and 2/2025 revealed Resident #39 had no monitoring for bleeding. During an interview on 2/27/2025 at 7:47 PM, the Director of Nursing (DON) confirmed Resident #39 had an order for Eliquis, however the facility failed to monitor Resident #39 for bleeding and bruising related to the use of Eliquis and monitoring should have been completed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974 Based on policy review, medical record review, observation, and interview, the facility failed to ensure a medication administration error rate of less than 5% (percent) when 2 of 5 nurses (Licensed Practical Nurse (LPN) W and X) failed to properly administer medications for 2 of 5 sampled residents (Resident #73 and #129) observed during medication administration. This resulted in a medication administration error rate of 12.5 % [percent] when 3 errors occurred out of 24 opportunities. The findings include: 1. Review of the facility's policy titled Administering Medications through an Enteral Tube, dated November 2018, revealed .Do not crush or split medications for administration through an enteral tube unless provider has given order to crush medications .dilute crushed (powered) medication with at least 30 ml [milliliter] purified water (or prescribed amount) .Administer medication by gravity flow .If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications . 2. Review of the medical record revealed Resident #73 was admitted on [DATE], with diagnoses including Esophagus Cancer, Respiratory Failure, Acute Kidney Failure, Dysphagia, and Sepsis. Review of the Physician Order dated 1/10/2025, revealed Levothyroxine Sodium Oral Tablet 75 MCG .Give 1 Tablet via PEG [Percutaneous Endoscopic Gastrostomy]-Tube at bedtime related to HYPOTHYROIDISM . Review of the Physician Order dated 2/3/2025 revealed Potassium Chloride ER [extended release] 10 MEQ [Milliequivalent] by mouth one time a day for hypokalemia . Review of the Medication Administration Record [MAR] dated 2/1/2025 to 2/28/2015 confirmed the Potassium pill was administered by mouth not by PEG [Percutaneous Endoscopic Gastrostomy] tube from 2/4/2025 through 2/28/2025. Review of the https://www.mayocinic.org website revealed Potassium supplement (oral route, parenteral route)- For patients taking the extended-release capsule for of this medicine: Do not crush or chew the capsule. Swallow the capsule whole with a full (8-ounce) glass of water . Review of the Medication Administration Record [MAR] dated 2-1-2025 -2-28-2015 confirmed the Levothyroxine Sodium Oral Tablet 75 MCG .Give 1 tablet via PEG -Tube at bedtime related to HYPOTHYROIDISM . Review of the Medication Administration Record [MAR] dated 2-1-2025 -2-28-2015 confirmed the Levothyroxine Sodium Oral Tablet 75 MCG was given at 8 PM each night. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation and interview on 2/27/2022 at 8:55 AM, outside Resident #73's room at the medication cart revealed (Licensed Practical Nurse LPN X) took out 5 medications that included a Potassium ER 10 Milliequivalents (Meq) 1 tablet and a Levothyroxine 75 mcg [micrograms] 1 tablet and crushed all 5 pills. LPN X spilled the crushed Levothyroxine on top of the medication cart. LPN X then stated, I will have to get the Unit Manager to get me another Levothyroxine out for me to give. I'm going to give the rest of these first. LPN X went into administer the medications by PEG. She administered the Potassium last, and it clogged the PEG tube. She disconnected the syringe and went to bathroom to run water through it to unclog. LPN X then completed the administration. Once LPN X was back to the medication cart she stated, In hindsight, I should have given the Potassium by mouth . During an interview on 2/27/2025 at 11:15 AM, LPN X was asked should she have crushed the Potassium ER tablet. LPN X stated, It is ordered by mouth . The first med error resulted when LPN X crushed the Levothyroxine with the morning meds, it was ordered to give by mouth at bedtime. The second med error resulted when LPN X crushed the Potassium Chloride Extended Release that should not be crushed for PEG tube administration. The Potassium Chloride ER was ordered to give by mouth. 3. Review of the medical record revealed Resident #129 was admitted to the facility on [DATE], with diagnoses including Tourette's Disorder, Diabetes, Chronic Kidney Disease Stage 3, Dysphagia, and Systemic Inflammatory Response Syndrome (SIRS). Review of the MAR dated 2/1/2025 - 2/28/2025 revealed Carbidopa- Levodopa Oral Tablet 25-100 MG [Milligrams] .Give 1 tablet by mouth three times a day for Parkinson's with meals . Observation on 2/27/2025 at 12:04 PM, outside Resident #129's room, at the medication cart revealed LPN W took out the Carbidopa- Levodopa Oral Tablet and crushed the tablet, put the crushed tablet in a medication cup. LPN X entered Resident #129's room, donned gloves, flushed PEG tube with 30 ml water, then poured 30 ml of water into the syringe and poured the crushed medication into the syringe without diluting with water. LPN W did not dilute the crushed medication prior to placing powder into syringe for administration and the order was to give by mouth. This resulted in the 3rd medication error. 4. During an interview on 2/28/2025 at 5:17 PM, the Director of Nursing (DON) was asked should a Potassium ER tablet be crushed and administered by a PEG tube. The DON stated, No. DON was asked should crushed medication be administered without diluting in a PEG tube. The DON stated No.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44724 Based on policy review, observation, and interview the facility failed to ensure medications were properly stored when 1 of 1 Licensed Practical Nurse (LPN DD) left 1 of 7 med storage areas unlocked and unattended, when medications were left on an over the bed table in 1 of 48 occupied rooms, and when 2 of 3 nurses Licensed Practical Nurse (LPN O and LPN X) left meds unattended and out of sight during medication administration. The findings include: 1. Review of the facility's policy titled, Storage of Medications, dated Revised November 2020, revealed .The facilities store all drugs and biologicals in a safe, secure, and orderly manner .Drugs and biologicals used in the facility are stored in locked compartments .The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Unlocked medication carts are not left unattended . 2. A random observation and interview in the 100 Hall on 2/24/2025 at 10:23 AM, revealed an unlocked unattended treatment cart. Licensed Practical Nurse (LPN DD) exited a resident's room, went to the unlocked treatment cart and opened the top drawer. LPN DD was asked about the treatment cart being left unlocked and unattended. LPN DD stated, It was not locked .I should have locked it. 3. Observation on 2/25/2025 at 9:04 AM, revealed (named) lidocaine (medication used to relieve pain) spray on the over the bed table next to Resident #39's bed and on the over the bed table that was positioned over Resident #39's bed. Observations on 2/27/2025 at 7:36 AM, room, revealed LPN O entered Resident #27's room, sat the medications on the over bed table and turned and left the room to go out to the medication cart to get gloves and left the 5 pills in a medication cup, 2 eye drops by the resident's bed out of sight and unattended. LPN O returned and administered the pills and administered the first eye drops. LPN O left the 2 eye medications out of sight again while she went to the bathroom to wash her hands. During an interview on 2/27/2025 at 8:39 AM, the Director of Nursing (DON) confirmed medications should be stored in a way that is inaccessible to others. Observation in Resident #73's room on 2/27/2025 at 8:55 AM, revealed Licensed Practical Nurse (LPN X) left medications unattended and out of sight during medication pass when she walked away from the meds and entered the bathroom to get water. During an observation and interview on 2/27/2025 at 8:56 AM, revealed a can of (named) lidocaine spray was on Resident #39's over the bed table. The DON confirmed the (named) lidocaine spray should not be stored on the resident over the bed table, it should be stored, locked and away from others who could get to it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/27/2025 at 11:51 AM, LPN X was asked should you have left the medications unattended and out of sight. LPN X stated, I shouldn't . During an interview on 2/27/2025 at 3:28 PM, LPN O was asked should you have left the medications out of sight and unattended in Resident #27's room. LPN O stated, I should have taken my meds with me. 46047

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47127 Based on the facility policy review, observations and interviews, the facility failed to properly label, date and store food items in the kitchen and failed to properly store, label and date personal resident food items in the 300 Hall nourishment room. The findings included: 1. Review of the facility policy titled Food Receiving and Storage dated November 2022, revealed .All food stored in the refrigerator or freezer are covered, labeled and dated ['use by' date] .All foods belonging to residents are labeled with the resident's name, the item and the 'use by' date .beverages are dated when opened and discarded after twenty-four (24) hours .partially eaten food is not kept in the refrigerator . Review of the facility policy titled Foods Brought by Family/Visitors dated February 2014, revealed .Intact fresh fruit may be stored without lid .Perishable foods must be stored in re-sealable containers with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the 'use by' date . 2. Observation during the initial kitchen walk-through on 2/24/2025 at 9:30 AM, revealed an opened container of chicken salad and an opened container of pimento cheese, neither were labeled with an open date or use by date. During an interview on 2/24/2025 at 9:45 AM, [NAME] C was asked what date the chicken salad and the pimento cheese had been opened? The [NAME] C stated, there was not a date on either item. During an interview on 2/24/2025 at 10:00 AM, the Dietary Manager was asked about the open date on the chicken salad and pimento cheese. The Dietary Manager agreed there was no date on either item and both should have been dated. 3. Observation in the kitchen on 2/25/2025 at 8:15 AM, revealed 4 uncovered pieces of raw bacon lying on the countertop. 4. Observation of 300 Hall Nourishment Room on 2/27/2025 at 4:00 PM, revealed 1 unlabeled and undated bag of grapes and 1 opened and undated bag of oranges in the refrigerator. An undated and opened container of juice was also present in the refrigerator. During an interview on 2/27/2025 at 4:42 PM, the Admission Nurse was asked how long juice was allowed to remain open in the refrigerator. She responded, The juice can stay in the refrigerator until the manufacture's expiration date. The Admission Nurse was also asked whether all items in the refrigerator should have the resident's names on them. She responded that all items should be labeled.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30974 Based on policy review, observation, and interview the facility failed to ensure practices to prevent the potential spread of infection were maintained when 3 of 3 nurses (Licensed Practical Nurse (LPN O, LPN W, LPN X) failed to clean reusable equipment before and after use and failed to use protective barriers, and when 1 of 3 nurses (LPN X) failed to wear Personal Protective Equipment (PPE) in enhanced barrier precaution rooms. The findings include: 1. Review of the facility's policy titled Enhanced Barrier Precautions, dated 2001, revealed Enhanced barrier precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents .EBPs are indicated .for resident with wounds and/or indwelling medical devices regardless of MDRO colonization .Indwelling medical devices include .feeding tubes . Review of the facility's policy titled, Handwashing/Hand Hygiene, dated October 2023, revealed .This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Hand hygiene is indicated .after contact with blood, body fluids, or contaminated surfaces .after touching a resident .after touching the resident's environment .immediately after glove removal . Review of the facility's policy titled Instillation of Eye Drops, dated February 2025, .Should both eyes require instillation, perform hand hygiene before treating each eye .Clean your equipment and return it to its designated storage area (i.e., bedside stand, bathroom, etc.) 2. A random observation in the 100 Hall on 2/24/2025 at 10:23 AM, revealed Licensed Practical Nurse (LPN DD) exited a resident's room with gloved hands, removed gloves and placed gloves in the trash on a treatment cart, failed to perform hand hygiene, and opened the top drawer of the treatment cart, and removed an item out of the drawer. During an interview on 2/27/2025 at 5:40 PM, the Infection Control Preventionist confirmed staff should not exit a resident's room with gloved hands and staff should perform hand hygiene after removing their gloves. 3. Review of the medical record revealed Resident #27 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Cardiomyopathy, Dysphagia, Dementia, and Insomnia. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed Resident #27's cognitive section was not documented. The quarterly MDS dated [DATE] had a Brief Interview for Mental Status (BIMS) score of 6, which indicated severe cognitive impairment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observations on 2/27/2025 at 7:36 AM, in Resident #27's room revealed LPN O, carried medications into the resident's room and sat the medicines on the over bed table without a protective barrier. LPN O then put one drop of Brimonidine Solution eye drop in the resident's left eye and immediately put one drop in the right eye. This did not follow the policy for administering eye drops. LPN O failed to perform hand hygiene between administering medicine in left and right eye. Then when LPN O administered the Refresh tears one drop to right eye and immediately one drop to the left without hand hygiene between. LPN O went back to the medication cart and retrieved the blood pressure (BP) machine placed it in her pocket and reentered the resident's room. Once LPN O took the resident's BP she placed the machine in her pocket and returned to medication cart. LPN O placed the BP machine on top of the cart until she had completed the computer work. Then placed the BP machine and eye drop bottles back into the cart drawers without disinfecting. 4. Review of the medical record revealed Resident #64 was admitted to the facility on [DATE], with diagnoses including Cerebral Infarction, Anxiety, Bipolar Disorder, Depression, Psychosis, and Dysphagia. Review of the quarterly MDS dated [DATE], revealed Resident #64 had a BIMS score of 13, which indicated moderate cognitive impairment. Observations on 2/27/2025 at 8:08 AM, in Resident #64's room revealed LPN O pulled scissors from her pocket and cut open the package for the medicated patch which had been laid on the bed, replaced scissors back into her pocket. LPN O failed to disinfect the scissors after use in Resident #64's room. 5. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE], with diagnoses including Pneumonia, Esophageal Cancer, Acute Kidney Disease, Chronic Ischemic Heart Failure, and Sepsis. Review of the admission MDS dated [DATE] revealed Resident #73 had a BIMS score of 11, which indicated moderate cognitive impairment. Observations on 2/27/2025 at 8:55 AM, in Resident #73's room, revealed LPN X entered to administer Percutaneous Endoscopic Gastrostomy (PEG) medications. LPN X failed to use a barrier on the over bed table when laid the medication down and failed to wear PPE in the enhanced barrier precautions room while administering medications. 6. Review of the medical record revealed Resident #129 was admitted to the facility on [DATE], with diagnoses including Tourette's Disorder, Diabetes, Chronic Kidney Disease, Systemic Inflammatory Response Syndrome (SIRS) and Anxiety. There was no MDS completed at this time due to the resident was a new admission. Observations on 2/27/2025 at 12:04 PM, in Resident #129's room, revealed LPN W entered the room, sat the med cup, water cups and syringe on over bed table without a protective barrier and failed to wear PPE in the enhanced barrier precaution room. 7. During an interview on 2/27/2025 at 3:28 PM, LPN O was asked should you have disinfected the eye drop bottles after setting them on the over bed table without a barrier and the BP machine after placing it in your pocket. LPN O stated, Yes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/27/2025 at 5:17 PM, the Director of Nursing (DON) was asked should PPEs be worn in enhanced barrier rooms during medication administration. The DON stated, Absolutely. During an interview on 2/27/2025 at 5:40 PM, the Infection Control Preventionist confirmed staff should not exit a resident's room with gloved hands and staff should perform hand hygiene after removing their gloves. 46047 47127

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 44724 Based on policy review, observation, and interview, the facility failed to provide and maintain a safe and sanitary environment for 11 of 48 occupied rooms (Resident #5, #9, #29, #36, #40, #44, #51, #65, #20 and #67's room, #68 and #27's room, and #72, and #73's room) when there was a broken/missing piece on the window blind, a sharp screw exposed on the closet door, there were holes in the wall, missing hooks from the privacy curtain, the air conditioner's front panel and filter was off, a cable cord box was not attached to the wall, there were bulging and missing pieces from the over tables, there were missing laminate pieces from the dresser and nightstands, plaster was peeling from the wall, uncovered corner pieces on the wall, a broken bed with no mattress stored in a resident's room, and when there were strong malodorous odors in residents' rooms. The findings include: 1. Review of the facility's policy titled, Maintenance Service, dated December 2024, revealed .Maintenance service shall be provided to all areas of the building, grounds, and equipment . 2. Observation in Resident #5's room on 2/24/2025 at 11:23 AM and 2/25/2025 at 8:48 AM, revealed the wall plaster peeling from the wall, and the laminate off the right side and bottom of the nightstand. 3. Observation in Resident #9's room on 2/25/2025 at 8:21 AM and 2/26/25 at 4:09 PM, revealed a broken/missing piece on the window blind, and a sharp screw exposed on the closet door due to the knob being off. 4. Residents #20 and #67 were roommates. Observation in Resident #20's room on 2/24/2025 at 11:31 AM and 2/25/2025 at 8:49 AM, revealed peeled plaster on the wall, a night stand with missing laminate strips on the left and right sides and the drawers, the over the bed table had a piece on the side that had come apart, and a holes in the wall. Observation in Resident # 67's room on 2/24/2025 at 11:32 AM, revealed crumbled plaster on the resident's wall. 5. Residents #27 and #68 were roommates. Observation in Resident #27's room on 2/24/2025 at 10:48 AM and at 4:13 PM, and 2/25/2025 at 8:30 AM, revealed the air conditioner had no front cover, the filter to the air conditioner was off, both side panels of the dresser had separated from the frame/coming off on both sides, the dresser was not upright/leaned back toward the wall, and the cable cord box was coming off /broken from the lower wall. Observation in Resident #68's room on 2/24/2025 at 10:49 AM and 2/26/2025 at 4:30 PM, revealed the top of the over the bed table had bulged/lifted from the frame and the wall had holes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445460	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc Vanco	813 S Dickerson Rd Goodlettsville, TN 37072

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Observation in Resident #29's room on 2/24/2025 at 11:16 AM and 2/25/2025 at 1:52 PM, revealed a dresser with missing laminate strips on the front sides and drawers. 7. Observation in Resident #36's room on 2/24/2025 at 4:05 PM, 2/25/2025 at 8:24 AM, and 2/26/2025 at 4:24 PM, revealed holes in the wall and 5 hooks missing from the privacy curtain. 8. Observation in Resident #40's room on 2/24/2025 at 11:46 AM and 2/25/2025 at 8:55 AM, revealed and nightstand and dresser with missing laminate strips. 9. Observation on 2/24/2025 at 10:45 AM, revealed Resident #44 was lying in bed with a sheet over his peri-area and no other clothes visible. There was trash, and soiled clothing items on the floor and multiple items cluttered on the overbed table, in chair, in wheelchair and throughout the room. The odor was malodorous and difficult to inhale. 10. Observation in Resident #51 on 2/24/2025 at 11:46 PM, revealed the nightstand had missing laminate strips on the left side. 11. Observation and interview on 2/24/2025 at 10:54 AM, revealed a bed frame with no mattress and metal rails were present on the A side of Resident #65's room. The bed frame was low to the floor. Resident #65 stated his bathroom was broken and he has been going across the hall to use the bathroom. 12. Observation on 2/25/2025 at 10:00 AM, revealed a strong odor present in Resident #72 and Resident #73's room. The odor smelled somewhat like decaying flesh. 13. During an interview and observation in Resident #5's room on 2/26/2025 at 4:53 PM, the Maintenance Supervisor confirmed Resident #5's dresser needed to be replaced and the resident's wall needed to be repaired. During an interview and observation in Resident #9's room on 2/26/2025 at 4:09 PM, the Maintenance Supervisor confirmed the blind and the closet doorknob needed to be replaced. During an interview and observation in Resident #20's room on 2/26/2025 at 5:01 PM, the Maintenance Supervisor confirmed the resident's corner wall needed a corner guard, the nightstand needed to be replaced, the walls needed to be repaired and painted, and the resident needed a new over bed table. During an interview and observation in Resident #27's on 2/26/2025 at 4:30 PM, the Maintenance Supervisor confirmed Resident # 27's air conditioner front panel, and the filter should not have been left off, the dresser needed to be replaced, and the cable cord box needed to be attached to the lower wall. During an interview and observation in Resident #29's room on 2/26/2025 at 4:59 PM, the Maintenance Supervisor confirmed Resident #29's dresser needed to be replaced with a new one. During an interview and observation in Resident #36's on 2/26/2025 at 4:24 PM, the Maintenance Supervisor confirmed the missing hooks on the privacy curtain needed to be replaced and there should be no holes in wall. (continued on next page)

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	445460	A. Building B. Wing	02/27/2025

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/24/2025 at 12:30, CNA L was asked what the staff did related to Resident 44's room. CNA L confirmed that resident had continued to keep the room in this condition despite daily room cleaning and nothing further had been done. During an interview and observation in Resident #65's room on 2/27/2025 at 11:20, revealed the Maintenance Director was asked what was wrong with the bathroom in Resident #65's room. The Maintenance Director stated the showers in the resident rooms were no longer being used. The shower was broken, and the toilet seat was loose. The Maintenance Director confirmed the lift motor was not working on the bed. During an interview on 2/27/2025 at 4:58 PM, the Administrator was asked whether he had been made aware of the bedframe being store on Resident #65's room. He stated, he was not aware of the broken bed being in the room and stated, .it is not an ideal situation and 100% there should have been a mattress on the bed . During an interview and observation in Resident #67's room on 2/26/2025 at 5:07 PM, the Maintenance Supervisor confirmed the resident's wall needed to be repaired. During an interview and observation in Resident #68's room on 2/26/2025 at 4:30 PM, the Maintenance Supervisor confirmed Resident #68's over the bed table needed to be replaced, and there should not be holes in the wall During an interview on 2/27/2025 at 11:45 AM, Housekeeper AA was asked if she had been made aware of specific provisions to prevent the wound related odors. The housekeeper stated, there has been no special provisions in place, and she has done everything that she could to try to help the smell. During an interview on 2/27/2025 at 12:00 PM, the Environmental Supervisor was asked whether she had been made aware of the odor present in Resident #72 and Resident #73. She stated the specialty cleaner that she ordered to help with the smell had not been delivered. During an interview on 2/27/2025 at 12:15 PM, the DON was asked what had been done regarding the smell in Resident #72 and Resident #73's room. The DON stated Resident #73 did not express that the smell was a problem. During an interview on 2/27/2025 at 2:30 PM, LPN W was asked what the smell was in Resident #72 and Resident #73's room. LPN W stated Resident #72 had skin cancer and has copious amounts of drainage from his wound which has been the cause of the odor. During an interview on 2/27/2025 at 5:00 PM, the Administrator was asked if he had been made aware of the odors present in Resident #72 and Resident #73's rooms and he stated they typically speak with the roommate to see whether there are any concerns related to the offensive smells. During an interview in the conference room on 02/27/2025 at 5:04 PM, the Administrator confirmed holes in the walls, over the bed tables, dressers and night stands with bulging and missing pieces, hooks missing hooks from privacy curtains, peeling plaster from walls, and an air conditioner with no front panel did not constitute a homelike environment for the residents. 46047