STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445461	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Magnolia Creek Nursing and Rehabilitation	1992 Hwy 51 S Covington, TN 38019

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 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. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, signed Job Description review, medical record review, and interview, the facility failed to ensure an injury of unknown origin was reported to the State Survey Agency (SSA) for 1 of 10 (Resident #1) sampled residents reviewed for abuse. The facility also failed to report the results of a thorough investigation for abuse within 5 working days to the SSA. The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, revised 5/2025, revealed .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.Abuse.includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm .Failure to implement effective communication system across all shifts for communicating necessary care and information between staff, practitioners and resident representatives.Prevention of Abuse, Neglect.The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict or neglect.Possible indicators of abuse include.Physical injury of a resident, of unknown source.Failure to provide care needs such as.safety.An immediate investigation is warranted when suspicion of abuse, neglect. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Heart Failure, Convulsion, and Hypertension. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severely cognitively impaired. Record review revealed on [DATE] at approximately 5:30 AM, nursing staff observed a swollen area on Resident #1's forehead above his left eyebrow. There was no documentation Resident #1 had fallen or sustained an injury. Resident #1 was found by Family Member (FM) E unresponsive and sent to the hospital for evaluation several hours later. Resident #1 underwent emergency surgery due to bleeding in the brain and was discharged to the hospice unit in house where he died on [DATE]. The facility did not investigate the injury of unknown origin and the cause of Resident #1's injury remains unknown. During a telephone interview on [DATE] at 11:39 PM, Licensed Practical Nurse (LPN) B stated on [DATE] at approximately 5:30 AM, Certified Nursing Assistant (CNA) A noticed a raised area on Resident #1's forehead above his left eye. LPN B stated Resident # 1 had been observed sleeping in bed through the night ([DATE]-[DATE]) and did not have any falls or known trauma to his head. LPN B was asked if she had asked Resident #1 what happened to cause the swollen area on his head. LPN B stated she did not ask Resident #1 what happened due to his severe cognitive impairment. LPN B was asked if she knew how Resident #1 sustained the hematoma on his forehead. LPN B stated the raised area was soft and squishy like an allergic reaction to a mosquito bite. LPN B concluded she did not know for certain what caused the raised area due to staff was not monitoring Resident #1 at all times. LPN B confirmed she did not believe Resident #1 had fallen or caused an injury to himself. LPN B was asked if she had received training for abuse which included recognizing and reporting an injury of unknown origin. LPN B stated she had received training on abuse and did not recall reporting injuries as suspected signs of abuse. During a telephone interview on [DATE] at 12:06 AM, CNA A stated on [DATE]-[DATE] she frequently observed Resident #1 in bed sleeping, and sitting on the side of the bed, which was in the lowest position. CNA A stated Resident #1 would get out of bed at times and wander around the Memory Care Unit. CNA A confirmed she was not always monitoring him during the night ([DATE]-[DATE]) because there were 15-16 other residents on the Memory Care Unit. CNA A was asked if she had received education on abuse which included recognizing and reporting an injury of unknown origin. CNA A confirmed she was not aware a head injury could be a sign of abuse. During an interview on [DATE] at 3:56 PM, Registered Nurse (RN) S stated her last abuse in-service was more than a year ago as she had just worked a minimal schedule while attending school. RN S stated she did not recall being given education related to reporting an injury of unknown origin as suspected abuse. During an interview on [DATE] at 4:49 PM, LPN U stated the last in-service training she received was within the past 3 months. LPN U did not recall specific training on injury of unknown origin being included in the reporting requirements for abuse. During an interview on [DATE] at 5:16 PM, RN N stated the last in-service on abuse was within the past year. RN N acknowledged she was not aware of the requirement to report an injury of

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility policy review, signed Job Description review, medical record review, and interview, the facility failed to investigate an injury of unknown origin for 1 of 10 (Resident #1) sampled residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation with a revision date of 5/2025, revealed .It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect.Abuse.includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.The facility will develop and implement written policies and procedures .to investigate any such allegations; and .Include training for new and existing staff on activities that constitute abuse .reporting procedures, and dementia management . Training topics will include .Identifying what constitutes abuse .Recognizing signs of abuse, neglect . Reporting process for abuse, neglect including injuries of unknown sources .Possible indicators of abuse include .Physical injury of a resident, of unknown source .Failure to provide care needs .An immediate investigation is warranted .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies .Immediately, but not later than 2 hours after the allegation . Review of the Director of Nursing's (DON) job description signed on 1/2020, revealed .To manage the overall operations of the Nursing Department in accordance with Company policies, standards of nursing practices and governmental regulations so as to maintain excellent care of all residents' needs. Management duties including.training and developing, coaching and counseling.Inform state of any reportable incidents within appropriate time frames. Complete investigative analysis as required.Study. Medication Incident Reports and Resident Incident Reports for corrective action. Review of the former Administrator's job description signed on [DATE], revealed .Lead and direct the overall operations of the facility in accordance with customer needs, government regulations and.policies . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Heart Failure, Convulsion, Hypertension, and Difficulty in walking. Review of the admission MDS assessment dated [DATE], revealed Resident #1 had a BIMS score of 0, which indicated severe cognitive impairment. Record review revealed on [DATE] at approximately 5:30 AM, nursing staff observed a swollen area on Resident #1's forehead above his left eyebrow. There was no documentation Resident #1 had experienced a fall or other cause of the resident's swollen area on the forehead. Resident #1 was found by Family Member (FM) E unresponsive and sent to the hospital for evaluation several hours later. Resident #1 underwent emergency surgery due to bleeding in the brain and was discharged to the hospice unit in house where he died on [DATE]. The facility did not investigate the injury of unknown origin and the cause of Resident #1's injury remains unknown. During a telephone interview on [DATE] at 11:39 PM, Licensed Practical Nurse (LPN) B stated Resident #1 was in bed all night ([DATE]-[DATE]/ 2025). Resident #1 was observed sleeping at times and sitting up on the side of the bed at times. The morning of [DATE], Certified Nursing Assistant (CNA) A got Resident #1 up and dressed then walked him to the hall without noticing the hematoma on his forehead. LPN B spoke to Resident #1 as he passed her in the hallway, without noticing the hematoma. Minutes later, Resident #1 walked to the door and CNA A noticed the raised area when she went to assist him. LPN B notified the telehealth provider and obtained orders to outline the raised area and monitor it for changes. LPN B stated the raised area was soft and squishy like an allergic reaction to a mosquito bite. LPN B was asked if she knew how Resident #1 sustained the hematoma on his forehead. LPN B stated, .I guess I couldn't say for sure because I wasn't with him all the time that night [[DATE]-[DATE]].we did not have him 1 on 1 [monitoring] every minute. I guess he could have fallen and got himself up.I know there wasn't an injury. LPN B confirmed she did not ask Resident #1 if he fell or what had happened due to his level of cognitive impairment because it wasn't likely he could tell her what happened. LPN B confirmed she was asked to provide a statement related to the [DATE] incident on [DATE], during the complaint survey. During a telephone interview on [DATE] at 12:06 AM CNA A stated she observed Resident #1 in bed sleeping, and at times sitting on the side of the bed, which was in the lowest position. CNA A stated Resident #1 could get up with the bed in the low level and would wander around the Memory Care Unit. CNA A confirmed she checked on Resident #1 during the night and was not always monitoring him, because there were 15-16 other residents on the memory care unit. CNA A stated, .I didn't see the place [hematoma] on his head the

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, ANA's [American Nurses Association] Principles for Nursing Documentation, review, job description review, medical record review, Neuro (Neurological) Check Assessment Form review, and interviews the facility failed to ensure treatment and care was provided in accordance with professional standards of practice, the comprehensive care plan and the resident's goals for care. The facility failed to promptly identify and intervene for an acute change in condition for 1 of 3 (Resident #1) sampled residents reviewed for quality of care. The facility's failure to ensure a resident received appropriate assessments and interventions resulted in Immediate Jeopardy when on [DATE] Resident #1 was noted to have a raised area on his left forehead. Nursing staff notified the contracted telehealth provider and failed to give complete, relevant, and accurate information resulting in Resident #1 remaining in the facility for 7 hours and 36 minutes before being transferred to the emergency room for evaluation of a life-threatening condition. Nursing staff also failed to notify a provider when Resident #1 had an acute change in condition from his baseline status resulting in the family requesting transfer to the hospital. Resident #1 was admitted to the hospital for a subdural hemorrhage on [DATE] and died on [DATE]. Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, the Director of Nursing (DON), the Regional Director of Operations (RDO), the Regional Director of Clinical Services (RDCS) and the Area Director of Clinical Services (ACDS) were notified of the Immediate Jeopardy (IJ) for F-684 during the complaint investigation on [DATE] at 7:39 PM, in the conference room. The facility was cited at F-684 at a scope and severity of J, which is Substandard Quality of Care. A partial extended survey was conducted from [DATE] through [DATE]. An acceptable Removal Plan, which removes the immediacy of the Jeopardy for F-684 was received on [DATE]. The Removal Plan was validated onsite by the surveyors on [DATE] through audit review, medical record review, observation, review of education records, and staff interviews. The IJ began on [DATE] and was removed on [DATE]. Noncompliance at F-684 continues at a scope and severity of D for monitoring the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction. The findings include: Review of the facility policy titled, Neurological Assessment, with a facility review date of [DATE], revealed, .It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury including Neurological Assessment. Guidelines.1. Neurological assessments are indicated.b. Following an unwitnessed fall.c. Following a fall or other accident/injury involving head trauma.d. When indicated by resident's condition.2. Any change in vital signs or/neurological status in a previously stable resident should be reported to the physician immediately. Compliance Guidelines.Resident Neurological Assessment.a. Vital signs.b. General condition and appearance.c. Neurological evaluation for changes in: i. Level of Consciousness.ii. Resident Response.iii. Movement.iv. Hand Grasp.v. Speech.vi. Pupil Reaction.vii. Pupil Size.d. Initial Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell, or bleeding. e. Initial Assessment of any injuries to head.5. Notify family and document all assessments, actions, and notifications. Review of the facility policy titled, Notification of Changes, revised on 6/2025, revealed, .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies.resident's representative when there is a change requiring notification.Life-Threatening Conditions Examples-Heart Attack or Stroke.Guidelines.Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status.Circumstances that require a need to alter treatment. Review of the undated Charge Nurse-Registered Nurse (RN)/Licensed Practical Nurse (LPN) job description revealed, .Complete accident/incident reports, as necessary.Chart nurses' notes in an informative and descriptive manner that reflects the care provided to the resident, as well as the resident's response to care.Write nurses' notes to reflect that the care plan is being followed when administering nursing care or treatment.Deliver and maintain optimum resident care and comfort by demonstrating knowledge and skills of current nursing practices.Notify the resident's attending physician when the resident is involved in an accident or incident.Monitor seriously ill residents, as necessary. The facility was unable to provide a policy for Nursing Services. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Heart Failure, Convulsion, Hypertension, Occlusion and stenosis of carotid artery, Difficulty in walking, Cognitive communication deficit, Anxiety disorder, and Insomnia. The

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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 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. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the American Nurses Association (ANA)'s Principles for Nursing Documentation review, facility policy review, medical record review, and interview, the facility failed to ensure medical records were complete and accurately documented for 1 of 7 (Resident #1) sampled residents reviewed. The findings include: Review of the ANA's Principles for Nursing Documentation dated 2010, revealed .Nurses document their work and outcomes for a number of reasons: the most important is for the communicating within the health care team . Nurses and other health care providers aim to share information about patients and organizational functions that is accurate, timely, contemporaneous, concise, thorough, organized, and confidential .Foremost of such electronic documentation is the electronic health record (EHR), provides an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR to support the ability of the health care team to ensure informed decisions and high-quality care in the continuity of the patient care .Assessments . Medication records (MAR) .Nursing Documentation Principles .Principle 1. Documentation Characteristics . High quality documentation is: Accurate, relevant, and consistent. Clear, concise, and complete. Timely, contemporaneous, and sequential. Reflective of the nursing process .Principle 5. Documentation Entries . Entries into organization documents or the health record (including but not limited to provider orders) must be: Accurate, valid, and complete; Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted; Dated and time-stamped by the persons who created the entry . Review of the facility policy titled, Documentation in Medical Record, with a facility review date of 1/2025, revealed .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident.information to provide a picture of he resident's progress through complete, accurate, and timely documentation.Licensed staff.shall document assessments, observations, and services provided in the resident's medical record.Documentation shall be completed at the time of service.Principles of documentation included.Documentation shall be factual.False information shall not be documented. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care. Review of the facility policy titled, Neurological Assessment, with a facility review date of 6/19/2025, revealed .It is the policy of this facility to report potential head injuries to the physician and implement interventions to prevent further injury including Neurological Assessment. Guidelines.When indicated by resident's condition.Any change in vital signs or/neurological status in a previously stable resident should be reported to the physician immediately.Compliance Guidelines.Resident Neurological Assessment.a. Vital signs.b. General condition and appearance.c. Neurological evaluation for changes in: i. Level of Consciousness.ii. Resident Response.iii. Movement.iv. Hand Grasp.v. Speech.vi. Pupil Reaction.vii. Pupil Size.d. Initial Evaluation of the head, eyes, ears, and nose for significant changes in vision, hearing, smell, or bleeding. e. Initial Assessment of any injuries to head.5. Notify family and document all assessments, actions, and notifications. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses which included Heart Failure, Convulsion, Hypertension, and Occlusion and stenosis of carotid artery. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 0, which indicated severe cognitive impairment. Review of the Medication Administration Record (MAR) for Resident #1 dated 5/4/2025, revealed administration of amlodipine (medication given for hypertension/high blood pressure) 10 mg (milligram) was administered to Resident #1 for an elevated BP (Blood Pressure-the force exerted by the blood on the walls of the arteries as it flows through them) of 168/122. There was no follow-up BP reading documented in the medical record. Review of the MAR for Resident #1 dated 5/5/2025, revealed Licensed Practical Nurse (LPN) O documented administration of amlodipine 10 mg for a BP of 173/121. There was no follow-up BP reading documented in the medical record. Review of the Nurse Practitioner's (NP) Progress Note for Resident #1 dated 5/5/2025, revealed, .no current reported concerns of.elevated blood pressure readings.no current nurse concerns reported . Review of the Medical Director's (MD) Progress Note for Resident #1 dated 5/6/2025, revealed no new event, no complaints, .Advised per progress . Review of the NP's Progress Note for Resident #1 dated 5/7/2025, revealed, .no current reported concerns of.elevated blood pressure readings.no current nurse concerns reported . Review of the MAR for Resident #1 dated 5/24/2025, revealed RN C documented an administration of carvedilol (medication for