STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445480	A. Building B. Wing	07/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Waters of Springfield LLC	704 5th Avenue East Springfield, TN 37172

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on interview, record review, and facility policy review, the facility failed to provide the required Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) for 1 (Resident #24) of 2 sampled residents reviewed for beneficiary notification. Findings included: 1. A facility policy titled, Advanced Beneficiary Notices, dated 11/2018, revealed, Policy: It is the policy of the facility to follow the Medicare requirements for issuing Advanced Beneficiary Notices and Notices of Non-Coverage of services as defined in the Medicare Claim Processing Manual, Chapter 30. Revision 4001, March 16th, 2018. Types of Notices: 1. Financial Liability: a. SNFABN - Traditional Medicare Part A only. The policy revealed, Overview of Financial Liability Notices - Medicare Beneficiaries have rights and protections related to their financial liability under Traditional Medicare. Advanced Beneficiary Notices (ABN) is to inform a Medicare Beneficiary, before he or she receives specified items or services that Medicare probably will not pay for them. Per the policy, 6. The SNFABN must be issued Prior to receiving the non-covered care (Upon admission or before) or (upon Termination of Medicare covered Skilled Care Needs - on or before the last covered day). 2. The Beneficiary Notice-Residents discharged within the Last Six Months form, completed by the facility indicated Resident #24 was discharged on [DATE] and remained in the facility. Resident #24's SNF Beneficiary Notification Review, completed by the facility, revealed the resident's start date of Medicare Part A Skilled Services was 06/07/2024 and the last covered day of Medicare Part A Skilled Services was 07/17/2024. The review indicated the facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The review indicated the facility did not provide the SNFABN, Form CMS-10055, to the resident because the resident discharged from the facility and did not receive non-covered services. During an interview on 07/23/2024 at 1:10 PM, the Business Office Manager (BOM) stated she thought the SNFABN needed to be given, but she was told by their corporate Minimum Data Set (MDS) staff that, since Resident #24 remained in the facility, they did not have to provide the SNFABN CMS-10055 to the resident. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 07/23/2024 at 1:15 PM, the Social Services Director (SSD) stated she was told by her MDS corporate office that the SNFABN did not have to be given if a resident remained in the facility. During an interview on 07/23/2024 at 1:30 PM, the MDS Coordinator stated she was not sure when the SNFABN needed to be provided. The MDS Coordinator stated she thought the facility cheat sheet showed that, since Resident #24 had skilled days remaining and remained in the facility and also went from Medicare to Medicaid, they would not need to give that notice. During an interview on 07/24/2024 at 3:52 PM, the Administrator and BOM stated they did not have an official beneficiary notice policy. During an interview on 07/25/2024 at 11:16 AM, the Administrator stated he did not know what the different notices were or what was required to be given to whom or when. The Administrator stated he expected they gave the notices in a timely manner to residents or their responsible parties and that they were given the appropriate notices. During an interview on 07/25/2024 at 11:30 AM, the Director of Nursing (DON) stated that she thought the form or discharge notice had to be issued within 24 hours before discharge. The DON stated she was not familiar with the CMS-10055 and that form was usually completed by the financial office. The DON stated she expected staff should be giving whatever notices were required by the regulations.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on record review, facility document review, facility policy review, and interview, the facility failed to protect the residents' right to be free from physical abuse perpetrated by other residents for 3 (Residents #33, #198, and #48) of 9 residents reviewed for abuse. Specifically, on 03/17/2024, Resident #29 hit Resident #33 with a meal tray. On 11/29/2023, Resident #10 struck Resident #198 on the right forearm and grabbed and pulled the resident's hair. On 12/19/2023, Resident #15 struck Resident #48, which caused the resident to fall backwards out of their wheelchair. Findings included: 1. A facility policy titled, Abuse Prevention Program, updated 01/19/2017, revealed, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. 2. An Admission Record revealed the facility admitted Resident #33 on 09/15/2021. According to the Admission Record, the resident had a medical history that included diagnoses of anxiety disorder, cognitive communication deficit, mild dementia with mood disturbance, and depression. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/08/2024, revealed Resident #33 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Resident #33's care plan revealed a focus area initiated 01/08/2024, that indicated the resident's comprehensive assessment indicated the resident had a history of suspected abuse, neglect exploitation, past trauma, and/or other factors that may increase susceptibility to abuse/neglect. An Admission Record revealed the facility readmitted Resident #29 on 11/09/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Chronic Pain Syndrome, Major Depressive Disorder, Anxiety Disorder, and Vascular Dementia. A quarterly MDS, with an ARD of 04/03/2024, revealed Resident #29 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. Resident #29's care plan revealed a focus area initiated 10/03/2023, that indicated the resident may exhibit signs or symptoms of anxiety as evidenced by episodes of agitation, restlessness, tearfulness, and worried facial expressions related to the resident's diagnosis of Anxiety. Interventions indicated that the resident may be referred to mental health services, including psychiatric consultations and psychotherapy services (initiated 10/03/2023). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29's Progress Notes dated 03/17/2024 at 7:38 PM, indicated it was reported that Resident #29 hit another resident with a meal tray. The note indicated the Administrator, Director of Nursing (DON), and a Nurse Practitioner were notified. The note indicated that an immediate intervention of one-to-one staff supervision was implemented and that the resident was going to be sent for a psychiatric evaluation. A facility investigation document, dated 03/17/2024, indicated that at around 6:30 PM, Registered Nurse (RN) #1 was alerted to a resident-to-resident event. The document indicated that Resident #29 attempted to take an uneaten meal tray when Resident #33 told Resident #29 not to. The document indicated Resident #29 proceeded to dump the tray and strike Resident #33 with the tray. The document indicated RN #1 separated the residents and called for assistance. Per the document, the Administrator was notified at 6:38 PM after RN #1 ensured the safety of the residents. The document indicated that Resident #33 was interviewed by the Administrator and stated that Resident #29 attempted to remove a meal tray with uneaten food when Resident #29 stated they should not do that. The document indicated Resident #33 stated that Resident #29 dumped the tray on the floor and hit them (Resident #33) in the head. The document indicated Resident #4, a witness to the incident, was interviewed and stated that when Resident #29 attempted to remove a meal tray with uneaten food, Resident #33 told them that they should not do that. The document indicated Resident #4 stated that Resident #29 dumped the tray and struck Resident #33 with the tray. The document indicated Resident #4 stated that staff immediately separated the two residents. During an interview on 07/24/2024 at 3:21 PM, Resident #4 stated they did remember the incident between the Resident #29 and Resident #33. Resident #4 stated Resident #29 was in the dining room and did not want the food they had been served, so Resident #29 took their tray to the cart and grabbed another tray that another resident had not eaten. Resident #4 stated Resident #33 just told Resident #29 to leave it alone, that they could not have it. Per Resident #4, Resident #29 got mad, threw the stuff off the tray and hit Resident #33 with it. Resident #4 stated that it was not a hard hit. Resident #4 stated it scared them when the incident occurred, but they currently felt safe. Resident #4 stated Resident #33 did not do anything, but just walked away. Resident #4 stated they left the room to go get staff to come in and help. Resident #4 stated the two residents were never in the dining room together following the incident. During a telephone interview on 07/24/2024 at 7:28 PM, RN #1 stated when she was notified of an incident between two residents, she first separated the residents and made sure they were both safe, then notified the Administrator and DON. She stated there was an incident several months ago where a resident came up to her and reported that there was an issue between Resident #29 and Resident #33. She stated the resident reported to her that Resident #29 picked up a tray and hit Resident #33 with it. RN #1 stated that was not behavior she had ever seen from Resident #29 before. She stated at the time, Resident #29's room was in the back and both residents ate in the same dining room. She stated she believed that one of the residents, she thought Resident #29, was sent out for an evaluation following the incident. She stated the resident who witnessed the incident told her that Resident #33 did not become aggressive and stated the resident was just sitting calmly in the dining room when she arrived. She stated, from what she could remember, Resident #29 was trying to get a sandwich and Resident #33 told the resident not to, that they were not supposed to have it. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 7/25/2024 at 9:38 AM, RN #2 stated that she had not worked at the facility since 04/07/2024. She stated she did remember the incident between Resident #29 and Resident #33. She stated the incident was unexpected for Resident #29 to have done something like that. She stated the residents were separated immediately. She stated she remembered that staff moved Resident #29 soon after the incident, sent the resident to the hospital for an evaluation, and kept the resident on one-to-one staff supervision for a while. She stated that as far as she knew, Resident #29 had never done anything like that before. During an interview on 07/25/2024 at 10:35 AM, Resident #33 stated they did remember the incident with Resident #29. The resident stated Resident #29 got mad, tried to take food off of old food trays. The resident stated when they told Resident #29 to stop, Resident #29 grabbed the tray and hit them with it. The resident stated that it did not hurt, stating I've got a hard head. Resident #33 stated they felt safe in the facility and had not seen that resident since. During an interview on 07/25/2024 at 11:30 AM, the DON stated if there was an instance of resident-to-resident abuse, when staff either heard of it or witnessed one resident swing at another resident, the first thing they needed to do was separate them and provide safety, then notify the abuse coordinator, the Administrator. She stated that interviews should be conducted about the incident immediately of anyone who had information regarding the incident. The DON stated she vaguely remembered the incident between Resident #29 and Resident #33. She stated that from what she remembered, Resident #29 was going to the meal cart, opened it, and was getting something off the cart. She stated that Resident #33 told Resident #29 to not touch it or mess with it. Per the DON, Resident #29 got upset and got the meal tray and hit Resident #33 in the face with the tray. She stated that Resident #29 was sent out to the hospital for an evaluation immediately after the incident. She stated that staff monitored Resident #29 closely prior to being sent out. Per the DON, there was not any bruising or redness to Resident #33. During an interview on 07/25/2024 at 11:16 AM, the Administrator stated that if there was a resident-to-resident altercation, staff should separate the residents immediately and ensure they were not injured then immediately notify him. He stated that if staff could not reach him, they should reach out to the DON. He stated that once notified, they started an investigation into the incident and put interventions in place. The Administrator stated that when they completed their investigation into the incident between Resident #29 and Resident #33, they found that it did happen, but they did not know what caused it. He stated that it was not normal behavior for Resident #29, who was usually a very quiet person. He stated that they did their best to prevent abuse. The Administrator stated that they discussed abuse monthly at their staff meetings, posted policies in the bathrooms, and had skills survey every year. PAST NON-COMPLIANCE VERIFICATION The facility implemented the following corrective actions: Resident #29's Psychological Diagnostic Interview, dated 03/18/2024 indicated that the resident medication regimen was reviewed and indicated that a depression screening was completed and was positive. The record indicated a plan for psychiatric services. Resident #29's Progress Notes dated 03/19/2024 at 11:00 AM, indicated the resident remained on one-to-one staff supervision while out of bed and every 15 minute checks when in bed. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #29's Progress Notes dated 03/20/2024 at 7:03 AM, indicated the resident remained on one-to-one staff supervision while out of bed and every 15 minute checks when in bed. Resident #29's Psychiatric Evaluation, dated 03/19/2024, indicated an evaluation was completed on that day. The record indicated a recommendation of an increase in an antidepressant medication and to discontinue one-to-one staff supervision. Resident #29's Psychiatric Evaluation, dated 03/26/2024, indicated the resident had a follow-up evaluation and indicated no changes in recommendations. An untitled facility document, dated 03/18/2024, indicated staff documented they provided one-to-one staff supervision for Resident #29 from 1:30 AM to 7:00 AM. Resident #33's Weekly Skin Check, dated 03/17/2024 at 7:54 PM, indicated the resident had no loss of skin integrity. Resident #33's Psychiatric Evaluation, dated 03/19/2024, indicated the resident was seen following a physical altercation with another resident and indicated that Resident #33 was not the instigator. The record indicated to continue with the current plan. 3. An Admission Record revealed the facility admitted Resident #10 on 08/10/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Anxiety, Dementia, and Paranoid Schizophrenia. An annual MDS, with an ARD of 07/01/2024, revealed Resident #10 had a BIMS score of 10, which indicated the resident had moderate cognitive impairment. Resident #10's care plan revealed a focus area initiated 08/25/2023, that indicated Resident #10 was at risk for alteration in behaviors as evidenced by mood alterations with schizophrenia, personal history of verbal outburst, and wandering. An Admission Record revealed the facility admitted Resident #198 on 08/03/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Vascular Dementia with Anxiety. A quarterly MDS, with an ARD of 03/28/2024, revealed Resident #198 was had a BIMS score of 0, which indicated severe cognitive impairment. Resident #10's Progress Notes dated 11/29/2023 at 7:02 PM, revealed the MDS Coordinator observed Resident #10 in their bedroom grabbing onto another resident's right forearm with one hand and handful of Resident #198's hair in their other hand. The note indicated the residents were separated. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A typed facility investigation, dated 11/29/2023, signed by the Administrator, indicated on 11/29/2023 at around 1:35 PM, Resident #10 struck Resident #198 on the right forearm and grabbed and pulled Resident #198's hair. The document indicated staff separated the residents and Resident #10 was placed on one-to-one staff supervision. The document indicated Resident #198 was interviewed and stated they tried to get into their room when Resident #10 struck their arm and pulled their hair. The document indicated Resident #198 stated that a nurse separated them. The document indicated Resident #41, Resident #198's and Resident #10's roommate, was interviewed and stated that Resident #10 struck Resident #198's arm, then pulled Resident #198's hair. The document indicated the facility concluded that the resident to resident event did occur. During an interview on 07/24/2024 at 2:55 PM, Resident #41 stated they were sitting with Resident #198 when Resident #10 approached them and started playing with Resident #198's hair. Resident #41 stated that Resident #10, without warning, started pulling out Resident #198's hair. Resident #41 stated that a nurse came and separated the two residents. During an interview on 07/25/2024 at 8:28 AM, Certified Nurse Aide (CNA) #27 stated that Resident #198 completed their lunch meal and was trying to get back into their room to lie down but crossed paths with Resident #10. CNA #27 stated that Resident #41 informed her that Resident #10 grabbed Resident #198 by the back of their head and pulled the resident out of their wheelchair. CNA #27 stated that by the time she arrived, the residents had already been separated. CNA #27 stated that she had not seen Resident #10 act like that before. She stated staff moved Resident #10 to the end of the hall so they could not have contact with Resident #198. During an interview on 07/25/2024 at 8:56 AM, the MDS Coordinator confirmed she was at the nursing station at the time that Resident #10 and Resident #198 had an altercation. The MDS Coordinator stated Resident #198 was in the way of Resident #10 and Resident #10 grabbed Resident #198's arm and pulled out their hair. She stated that she notified the Administrator, physicians, and family. She stated Resident #10 was sent out for a psychiatric evaluation. During an interview on 07/25/2024 at 9:57 AM, the DON stated that in the event of an abuse allegation it was her expectation of staff to ensure all parties were safe, notify the nurse on the floor and for the nurse to immediately notify the abuse coordinator, the Administrator. During an interview on 07/25/2024 at 10:06 AM, the Administer stated it was reported to him that Resident #10 pulled Resident #198's hair. He stated the residents were separated, and the incident was reported to the state survey agency and the policy. He stated the management team then conducted an investigation and Resident #10 was sent out for a psychiatric evaluation. PAST NON-COMPLIANCE VERIFICATION The facility implemented the following corrective actions: The facility's Investigation Timeline indicated on 12/29/2023 at approximately 2:30 PM, emergency medical services (EMS) arrived at the facility and at 2:41 PM, Resident #10 was taken by EMS. A facility document titled Every 15 minute checks, dated 11/29/2023, indicated staff documented that one-to-one staff supervision was provided to Resident #10 until EMS to the facility to take the resident to the hospital. Documentation revealed staff documented from 1:30 PM to 2:30 PM. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #10's Progress Notes dated 11/29/2023, indicated the resident was sent to the emergency room for evaluation. A note dated 12/14/2023 indicated the resident returned to the facility on that day. Resident #198's Pain Review, dated 11/29/2023 at 4:13 PM, indicated the resident had throbbing pain to the back of their head and scalp and indicated that it Hurts a Little Bit. A facility document titled, Training Log/Sign In Sheet, dated 11/29/2023, indicated staff received training on the facility's abuse policy, reporting abuse, types of abuse, and the grievance process. 4. An Admission Record revealed the facility admitted Resident #15 on 02/14/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Dementia, Depressive episodes, Restlessness and Agitation. A quarterly MDS, with an ARD of 06/06/2024, revealed Resident #15 had a BIMS score of 5, which indicated the resident had severe cognitive impairment. Resident #15's care plan included a focus area initiated 08/01/2022, that indicated the resident had an alteration in behaviors as evidenced by being resistant to care and indicated that the resident was verbally aggressive to staff and combative with care. An Admission Record revealed the facility admitted Resident #48 on 06/21/2022. According to the Admission Record, the resident had a medical history that included diagnoses of Dementia, Cerebral Infarction (a stroke) without residual deficits, Anxiety Disorder, and Traumatic Amputation at level between right hip and knee. A significant change in status MDS, with an ARD of 05/29/2024, revealed Resident #48 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. Resident #48's Progress Notes dated 12/19/2023 at 10:45 AM, revealed staff requested assistance because two residents had an altercation. The note indicated Resident #15 was on the ground and their wheelchair was flipped over. The note indicated the resident was helped back up and the two residents were separated. Resident #15's Progress Notes dated 12/19/2023 at 10:45 AM, indicated the resident had been in an altercation with another resident (Resident #48) and was separated from the other resident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A typed facility investigation, dated 12/19/2023, indicated Resident #15 and Resident #48 were outside for a smoke break. The document indicated Resident #15 attempted to take a lighter and when a staff member attempted to redirect the resident, Resident #15 made a rude remark to the staff member. The document indicated Resident #48 then made a comment to Resident #15, at which time Resident #15 stood up and began to approach Resident #48. The document indicated Housekeeping Aide (HA) #21 attempted to stand between the two residents but Resident #15 struck Resident #48, causing the resident to fall backwards. The document indicated HA #21 alerted other staff members and both residents were separated, and Resident #15 was placed on one-to-one staff supervision. The document indicated Resident #48 was assessed and denied pain and had no physical injuries. The document indicated Resident #15 was sent to the emergency room for a psychiatric evaluation. Per the document, the facility's investigation found that the incident did occur and staff acted in the best interest of the residents, attempting to prevent the incident and seeking immediate assistance after the event. During an interview on 07/24/2024 at 12:59 PM, HA #21 stated she was monitoring residents in the designated smoking area when Resident #15 and Resident #48 got into an altercation. HA #21 stated Resident #15 grabbed a cigarette lighter, and she told the resident that they had to wait for staff to light their cigarette. She stated Resident #15 indicated that they were an adult, then Resident #48 told Resident #15 to have respect for HA #21. She stated that Resident #15 started cussing at Resident #48, then Resident #15 stood up and hit Resident #48 in the face, knocking the resident out of the wheelchair. HA #21 stated that they then yelled for help and Physical Therapist (PT) #28, along with two other staff, including the Administrator, arrived and assisted Resident #48 back into their wheelchair. During an interview on 07/24/2024 at 1:31 PM, Resident #35 stated they were sitting in the smoking area at the time of the incident between Resident #15 and Resident #48. Resident #35 stated that Resident #15 and Resident #48 were both talking to each other when Resident #48 started cursing at Resident #15. Resident #35 stated Resident #15 then hit Resident #48 in the face, knocking the resident over. Resident #35 stated staff then came and separated the two of them and helped Resident #48 off the ground. During an interview on 07/24/2024 at 1:46 PM, PT #28 stated he heard a staff member yelling for help and when he got to the smoking area, Resident #48 was on their back. He stated that he was told that Resident #15 came over on top of Resident #48 and they were fighting. He stated that the residents were separated. During an interview on 07/24/2024 at 4:09 PM, Resident #32 stated they was sitting on the smoking deck at the time of the incident. The resident stated Resident #48 was antagonizing Resident #15. Per Resident #32, Resident #15 told Resident #48 to stop antagonizing Resident #15 or they would hit them. The resident stated that Resident #48 did not stop, and Resident #15 punched Resident #48, knocking them out of their chair. During an interview on 07/25/2024 at 9:57 AM, the Director of Nursing (DON) stated she was not employed at the time of the incident. The DON stated that in the event of an abuse allegation it was her expectation of staff to ensure all parties were safe, notify the nurse on the floor and for the nurse to immediately notify the abuse coordinator, the Administrator. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 07/25/2024 at 10:06 AM, the Administrator stated that by the time he arrived at the smoking area, staff had already separated Resident #15 and Resident #48. He stated he reported the incident to his boss, the police, and the state survey agency. The Administrator stated it was his expectation to be contacted immediately for physical abuse allegations. PAST NON-COMPLIANCE VERIFICATION The facility implemented the following corrective actions: A facility document indicated staff document one-to-one supervision was provided to Resident #15 until EMS transported the resident on 12/19/2023. Documentation revealed staff documented the supervision from 10:45 AM to 12:00 PM. Resident #48's skin assessment dated [DATE] revealed No issues noted. Resident #15's Progress Notes revealed the following notes: A note dated 12/19/2023 at 12:01 PM indicated Resident #15 was sent to the emergency room for an evaluation and treatment following an altercation with Resident #48. A note dated 12/19/2023 at 10:45 PM indicated that Resident #15 returned to the facility from the emergency room . A note dated 12/20/2023 at 6:25 PM indicated that Resident #15 struck a nurse and was sent back to the emergency room . A note dated 12/20/2023 at 11:12 PM indicated that Resident #15 returned to the facility from the hospital. A note dated 12/20/2023 indicated that Resident #15 was to stay on one-to-one supervision to prevent future altercations until the resident was transferred to another facility. A note dated 12/22/2023 at 3:42 PM indicated that Resident #15 was transferred to a psychiatric hospital. Facility documents titled, Training Log/Sign In Sheet, dated 12/20/2023, indicated staff received training on reporting change in behaviors to a charge nurse immediately, and if there is a verbal or physical altercation involving a resident, never leave the resident, call for help. The facility has continued to supervise these residents' behaviors without recurrence.

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	445480	A. Building B. Wing	07/25/2024

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The Waters of Springfield LLC	704 5th Avenue East Springfield, TN 37172

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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. 18639 Based on record review, interview, document review, and facility policy review, the facility failed to report an allegation of abuse to the State Survey Agency (SSA) for 1 (Resident #36) of 7 sampled residents reviewed for abuse. Findings included: 1. A facility policy titled, Abuse Prevention Program, updated 01/19/2017, indicated, It is the policy of this facility to prevent resident abuse, neglect, mistreatment and misappropriation of resident property. Each resident receives care and services in a person-centered environment in which all individuals are treated as human beings. The following Procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. The policy further indicated, When an alleged or suspected case of abuse or neglect is reported to the Administrator, the Administrator, or person in charge of the facility, will notify the following persons or agencies of such incident immediately. State Licensing and Certification Agency (i.e. [id est, that is] TDH [Tennessee Department of Health (SSA)]). 2. An Admission Record revealed the facility admitted Resident #36 on 08/10/2023. According to the Admission Record, the resident had a medical history that included diagnoses of Mood Disorder due to known physiological condition with Major Depressive-like episode and Malignant Neoplasm of the right breast. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 05/16/2024, revealed Resident #36 had a Brief Interview for Mental Status score of 10, which indicated the resident had moderate cognitive impairment. Resident #36's care plan included a focus area initiated 08/21/2023, that indicated the resident had a self-care deficit. Interventions indicated the resident required extensive assistance from two staff with bed mobility and transfers (initiated 08/21/2023), and required extensive assistance from one staff with toileting, eating, bathing, dressing, and mobility on the unit (initiated 08/21/2023). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A typed facility investigation document, dated 05/22/2024, indicated Family Member (FM) #23, a family member of Resident #36, approached Registered Nurse (RN) #12 and Certified Nurse Aide (CNA) #30 on 05/22/2024 and asked to speak with the man who had been going in their family member's room, touching and trying to kiss the resident. The document indicated that the staff told FM #23 they did not know what man they were referring to, but FM #23 could speak to the Administrator or the Director of Nursing (DON). The document indicated FM #23 left the building and staff immediately notified the Administrator of the concern. The document indicated that the Administrator and DON contacted FM #23 who stated that Resident #36 told them that a couple weeks ago, a man came into their room, told them they had beautiful body parts and began to touch Resident #36. The document indicated that Resident #36 was interviewed and indicated that a man came into their room in the past couple of days and told them they had beautiful body parts and began touching them. The document indicated that Resident #36 told the person to stop at which time, the person stopped and left the room. The facility investigation documents revealed no indication the allegation of sexual abuse had been reported to the state survey agency. During an interview on 07/24/2024 at 12:07 PM, the Administrator stated FM #23 reported an allegation of sexual abuse to facility staff, and he was contacted immediately. The Administrator stated it had been determined within two hours of the initial reporting of the allegation to the facility staff that the alleged incident had not occurred and therefore, the allegation was not reported to the TDH (SSA). During an interview on 07/24/2024 at 1:27 PM, the DON stated the incident was not reported to the TDH (SSA) because Resident #36 recanted the allegation within a two-hour period after initially reporting the allegation to the staff. During an interview on 07/25/2024 at 11:20 AM, the DON stated she was now aware any allegation of abuse, neglect, or misappropriation must be reported to the proper authorities per the facility's policy. During an interview on 07/25/24 at 12:21 PM, the Administrator stated he understood all allegations of abuse must be reported to appropriate state agencies.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49044 Based on observation, interview, record review, and facility policy review, the facility failed to arrange a follow-up appointment with an ophthalmologist based on a recommendation made by the optometrist for 1 (Resident #25) of 2 sampled residents reviewed for vision services. Findings included: 1. A facility policy titled, Vision Service, dated 05/14/2023 revealed, Policy: It is the policy of the facility to provide medically related social services to attain or maintain the highest practicable physical, mental and psychological well-being of each resident. This includes meeting any need for vision care to include routine as well as emergency indicated services. The policy indicated, 6) SSD [Social Services Director] will work with the resident, family, physician, optometrist and/or ophthalmologist to coordinate timely care. Per the policy, Note: Negative findings will be immediately addressed. The attending physician will be notified as well as the facility's visual provider. The DON [Director of Nursing], MDS [Minimum Data Set] Coordinator and SSD will also be notified as well as the resident of their responsible party. 2. An Admission Record revealed Resident #25 admitted to the facility on [DATE]. According to the Admission Record, the resident had a medical history that included diagnoses of Type 2 Diabetes Mellitus, Hypertension, and Dry Eye Syndrome. Resident #25's care plan included a focus area, initiated 02/07/2023, that indicated the resident had dry eye syndrome. Interventions directed staff to observe for changes in visual status and to have ophthalmology or optometry appointments as indicated. Resident #25's optometrist's Eye Care Chart Note, dated 03/07/2024, revealed Resident #25 presented as a new patient for an evaluation of the right and left eye due to Diabetes Mellitus and Systemic Hypertension, which occurred daily and affected both eyes. The note revealed an assessment plan that indicated a cataract of the left eye and specified, Cataracts are visually significant; Please schedule for cataract evaluation with Ophthalmologist of facility choice. A quarterly MDS, with an Assessment Reference Date (ARD) of 04/28/2024, revealed Resident #25 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The MDS indicated the resident had moderately impaired vision and needed corrective lenses. During a concurrent observation and interview on 07/22/2024 at 1:25 PM, the surveyor noted Resident #25's right eye was significantly smaller than the left eye. Resident #25 stated they were blind in their right eye and had cataracts in their left eye. Resident #25 stated they needed surgery but were unsure where the facility was with scheduling it. Resident #25's Progress Notes, dated 01/01/2024 through 07/24/2024, revealed no evidence to indicate the resident was evaluated by an ophthalmologist. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #25's Order Summary Report, with active orders as of 07/24/2024, revealed an order dated 07/15/2022, that specified the resident may receive services of eye care, audiologist, podiatrist, dental, psychiatrist, cardiologist, physiatrist, nurse practitioner, wound physician and any other specialist as deemed necessary. During a concurrent record review and interview on 07/24/2024 at 10:23 AM, the SSD reviewed Resident #25's electronic medical record and stated she did not see any notes recently from the vision provider for the resident or any records of appointments with the vision provider. The SSD stated she did not know anything about Resident #25 needing a follow-up appointment. During an interview on 07/24/2024 at 2:56 PM, the SSD stated she had to call the vision provider to obtain the records from Resident #25's most recent eye appointment, and she had not seen the report. The SSD stated she was not aware that the optometrist had written that the resident needed to have cataract surgery, and, if she had, it would have already been scheduled and completed. During an interview on 07/25/2024 at 9:25 AM, the SSD stated she understood they missed Resident #25's appointment for an evaluation for cataract surgery. The SSD stated the vision provider was supposed to let the facility know if there were follow-up appointments that needed to be made. The SSD stated since she was not working at the facility in March 2022, when Resident #25 was seen by the optometrist, she did not know what happened. The SSD stated that, as far as she could tell, there had not been communication between the vision provider and the facility to let them know if a resident needed further evaluation. During an interview on 07/25/2024 at 11:16 AM, the Administrator stated he thought the vision provider came to the facility quarterly, and after a resident was seen by the vision provider their documentation was emailed to the SSD. The Administrator stated, even though the SSD had only been in that role since March 2024, the emails would have been assumed by the person taking that role, and the current SSD should have had access to all the emails sent by the vision provider. The Administrator stated, if nursing was aware of the resident's need for an appointment and the resident had not been seen in a timely manner, nursing would bring it up in their morning meeting. The Administrator stated he did not recall that anyone spoke about Resident #25 needing to be seen by an ophthalmologist for cataract surgery, and he was not aware that Resident #25 needed that surgery. The Administrator stated he expected residents' vision, dental, and hearing needs to be met timely and appointments with outside providers to be scheduled timely. During an interview on 07/25/2024 at 11:30 AM, the DON stated she was not aware prior to 07/24/2024 that Resident #25 needed to have cataract surgery. The DON stated there were some issues with the previous social worker not getting the residents the appointments they needed timely.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 39714 Based on observation, interview, and facility policy review, the facility failed to label and date food items in a walk-in refrigerator. This had the potential to affect all residents who received food from the kitchen. Findings included: 1. An undated facility policy titled, Food Safety, indicated, Food items that do not have a manufacturer's expiration date will be labeled and dated with a received and use by date. 2. During a tour of the kitchen on 07/22/2024 at 8:50 AM, with the Dietary Director (DD), the following was observed in the walk-in refrigerator: Six, undated bowls of salad; Four, small, undated bowls of pears; Four, small, undated and unlabeled bowls of yellow pudding; Two, undated and unlabeled pieces of meat, of which the DD identified as country fried steak; and Two, unlabeled and undated bowls of white sauce, of which the DD stated was tartar sauce. During an interview on 07/24/2024 at 4:02 PM, [NAME] #10 stated all foods had to be labeled and dated after being opened. [NAME] #10 stated leftover foods were wrapped, dated, and used within three days. During an interview on 07/25/2024 at 8:44 AM, [NAME] #11 stated all food items should be labeled and dated when opened. During an interview on 07/25/2024 at 9:27 AM, the DD stated it was her expectation for staff to date food items upon receipt. The DD stated it was her expectation for opened foods to be labeled with opened and use by dates. During an interview on 07/25/2024 at 9:36 AM, the Registered Dietician stated it was her expectation that all opened foods should be labeled and dated with an opened and use by date. During an interview on 07/25/2024 at 9:57 AM, the Director of Nursing stated all opened food items should be labeled and dated. During an interview on 07/25/2024 at 10:06 AM, the Administrator stated all food items should be dated and labeled.