STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445507	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hickory Woods	4200 Murfreesboro Pike Antioch, TN 37013

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 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** 46252 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure call lights were within reach for 1 of 118 (Resident #82) sampled residents reviewed for access to call lights. The findings include: Review of the facility's policy titled, Resident Call System, revised on 1/4/2023, revealed, .The nurses' stations in the facility will be equipped to receive resident calls with a communication system through audible or visual signals from resident rooms .The call light should be positioned in reach of the resident .The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room . Review of the medical record revealed Resident #82 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Hemiplegia and Hemiparesis (conditions that cause weakness or paralysis of one side of the body) following cerebral Infarction (condition that occurs when blood flow to the brain is blocked) affecting Left Non-Dominant side, Type 2 Diabetes Mellitus with Hyperglycemia, Displaced Intertrochanteric Fracture of Left Femur, and Dysphagia (swallowing difficulties) following Cerebral Infarction. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #82 had a Brief Interview for Mental Status (BIMS) score of 7 which indicated severe cognitive impairment. Resident #82 required supervision to total assistance with Activities of Daily Living [ADL]s. Observation in Resident #82's room on 8/19/2024 at 10:15 AM, revealed Resident #82 lying in bed on her back with the call light on the floor on the side of the bed next to the room door. Observation and interview in Resident #82's room on 8/19/2024 at 10:18 AM, Licensed Practical Nurse (LPN) G confirmed the call light was on the floor on the side of the bed next to the room door and the call light was not within Resident #82's reach. LPN G stated, .Call lights should be in residents' reach . During an interview in the 100 Hall on 8/20/2024 at 12:32 PM, LPN J the 100 Hall Unit Manager confirmed call lights should be within residents' reach when in their beds. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hickory Woods	4200 Murfreesboro Pike Antioch, TN 37013

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview in the conference room on 8/21/2024 at 3:50 PM, the Director of Nursing (DON) confirmed call lights should be within the residents' reach while in their rooms.

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Hickory Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Murfreesboro Pike Antioch, TN 37013	

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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	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** 44724 Based on facility policy review, medical record review, Facility Reported Investigation (FRI) review, and interview, the facility failed to report allegations of abuse within 2 hours for 2 of 3 (Residents #170 and #270) sampled residents reviewed for abuse. The findings include: Review of the facility policy titled, Incident and Reportable Event Management, with revision date of 5/4/2023 revealed, .Reporting of Alleged Violations .Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment .are reported immediately, but not later than 2 hours after the allegation is made . Review of the medical record revealed Resident #170 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Altered Mental Status, Cognitive Communication Deficit, Type 2 Diabetes Mellitus with Diabetic Neuropathy, and Atherosclerotic Heart Disease. Review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #170 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated no cognitive impairment. Review of the Incident Description dated 8/28/2023 revealed .Resident [Resident #170] was on the hallway angry swinging her cane and talking loud .a [Resident #270] was in her room, and he was aggressive and being racist when she told him to get out of her room . Review of the medical record revealed Resident #270 was admitted to the facility on [DATE] and discharged on [DATE] with a diagnosis which included Anxiety, Cognitive Communication Deficit, Adjustment Disorder with Disturbance of Conduct, and Dementia. Review of the MDS dated [DATE] revealed Resident #270 had a BIMS score of 4 which indicated severe cognitive impairment. Review of the Incident Description dated 8/28/2023 revealed Resident #270 was confused and was not aware of the situation and stated, today is my birthday, and he went in his room and got his birthday card to show the nurse. Continued review of the Incident Description revealed Resident #270 was a wanderer. Resident #270 was redirected to his room and closely supervised until he was transferred to the ER (emergency room). (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the FRI #20230829155745 revealed on 8/28/2023 at 4:48 PM, Resident #170 reported to her nurse that another resident (Resident #270) came into her room and hit her. Resident #170 reported Resident #270 swung an open hand at her and scratched the right side of her face. Both residents received a head-to-toe skin assessment with no visible bruises or other injuries noted. Both residents were immediately separated from one another. Review of the facility investigation revealed no employee witnessed the incident, but Resident #270 was observed coming from the direction of Resident #170's room. Resident #270 with a BIMS score of 4 and cognitive communication deficit was unable to give any details. Resident #270 was sent to the ER for an immediate psychiatric evaluation and returned back to the facility. Resident #270 was placed on 1:1 supervision until he was transferred to another facility. The FRI review revealed the allegation of physical abuse was not reported timely. The incident occurred on 8/28/2023 at 4:48 PM but was not reported to the state agency until 8/29/2023 at 4:27 PM. During an interview on 8/13/2023 at 12:15 PM, Certified Nursing Assistant (CNA) M stated, .I was here the day that [Named Resident #170] said [Named Resident #270] hit her . During an interview on 8/14/2024 at 6:30 PM, Family Member R stated, .My sister was on the phone with [Resident #170] when the other resident came in her room. He [Resident #270] argued that was his room and she [Resident #170] said he hit her . During an interview on 8/22/2024 at 2:07 PM, the Administrator was asked when an allegation of abuse occurs when should it be reported to the state agency. The Administrator stated, .allegation of abuse should be reported immediately within 2 hours . The Administrator was asked to provide this surveyor with documentation of timely reporting of the incident. The Administrator could not provide documentation to prove the FRI #20230829155745 was reported timely.

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of Hickory Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 4200 Murfreesboro Pike Antioch, TN 37013	

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46252 Based on facility policy review, Resident Assessment Instrument (RAI) Version 3.0 Manual review, medical record review, and interview, the facility failed to complete a Significant Change Minimum Data Set (MDS) assessment for 1 of 4 residents (Resident #273) reviewed. The findings include: Review of the facility's policy titled, Resident Assessment Instrument & Care Plan Development, revised [DATE], revealed, .The facility will follow the procedures set forth in the Resident Assessment Instrument (RAI) User's Manual 3.0 when completing the MDS, Care Area Assessment, and Comprehensive Care Plan . MDS assessments are completed at a minimum upon admission, quarterly, and with a significant change in patient status . Review of the RAI Version 3.0 Manual revealed, .When a SNF [Skilled Nursing Facility] or NF [Nursing Facility] is the hospice resident's residence for purposes of the hospice benefit .the resident must be assessed using the RAI .Comprehensive assessments are completed upon admission, annually, and when a significant change in a resident's status has occurred .Significant Change in Status Assessment [SCSA] .The SCSA is a comprehensive assessment for a resident that must be completed .when a terminally ill resident enrolls in a hospice . Review of the medical record revealed Resident #273 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Encounter for Surgical Aftercare following Surgery on the digestive System, Type 2 Diabetes Mellitus without complications, Moderate Protein-Calorie Malnutrition, Diverticulosis of Intestine, Acute Kidney Failure, Personal History of other Malignant Neoplasm of Large Intestine, and Vascular Dementia. Resident #273 expired on [DATE]. Review of the Order Summary Report for Resident #273, revealed an order dated [DATE], .Admit to [Named Hospice Agency] end of life care . Review of the Quarterly MDS assessment dated [DATE] revealed Resident #273 had a Brief Interview of Mental Status (BIMS) score of 3 which indicated severe cognitive impairment. The MDS assessment revealed, Hospice Care was not documented for Resident #273 while under hospice services. Review of the medical record for Resident #273 revealed, no Significant Change MDS assessment was completed for hospice services received by Resident #273. During a telephone interview on [DATE] at 8:37 AM, Registered Nurse (RN) SS confirmed Resident #273 received hospice services from [DATE] through [DATE]. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview in the MDS Coordinator's Office on [DATE] at 10:15 AM, MDS Licensed Practical Nurse (LPN) TT and MDS RN P were asked when a resident is admitted to hospice services would an MDS assessment be performed? MDS LPN TT stated. When a resident goes on hospice services a Significant Change MDS assessment should be performed and submitted.When asked if there were any situations when a resident is admitted to hospice services that a Significant Change MDS assessment would not be done. The MDS RN P and MDS LPN TT both stated, no, that a Significant Change MDS assessment should always be submitted when a resident goes on hospice services. When asked to review Resident #273 medical record, both MDS LPN TT and MDS RN P, confirmed no Significant Change MDS assessment was submitted when Resident #273 was placed on hospice services on [DATE]. Both MDS LPN TT and MDS RN P confirmed on the Quarterly MDS assessment for Resident #273 dated [DATE], hospice care was not documented in Section O. During a telephone interview on [DATE] at 1:55 PM, the named hospice agency's Clinical Director (RN WW) stated Resident #273 received hospice services at the facility from [DATE] through [DATE].

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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, document review, and interview the facility failed to revise care plans for 2 of 5 (Residents #170 and #270) sampled residents reviewed for resident-to-resident physical altercations, 1 of 6 (Resident #175) sampled residents reviewed for fall interventions, 1 of 3 (Resident #111) sampled residents with urinary catheters, 1 of 5 (Resident #18) sampled residents reviewed for changes to antipsychotic medication, and 1 of 4 (Resident #273) sampled residents reviewed for hospice services. The findings include: Review of the facility's policy titled, Comprehensive Care Plan and Revision dated [DATE], revealed, .The facility will ensure .that the comprehensive care plan is reviewed and revised by an interdisciplinary team . The facility should monitor the resident over time to help identify changes in the resident condition that may warrant an update to the person-centered plan of care .When changes occur, the facility should review and update the plan of care to reflect the changes to care delivery, this can include .Additional interventions on existing problems .Updating goal or problem statements .Adding a short-term problem, goal, and interventions to address a time limited condition . Review of the facility's policy tilted, Incident and Reportable Event Management, with review date of [DATE], revealed, .Event Management includes, but is not limited to .Fall Unwitnessed or Witnessed .To help reduce the risk of an event .The licensed nurse should implement an appropriate immediate intervention, based on the conclusions of the initial investigation .The license nurse would update the residents [residents'] care plan and communicate the intervention to the staff caring for the resident .The IDT [Interdisciplinary Team] will as part of their review, determine if the initial interventions is sufficient or if a modification is needed . Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease, Dementia, Anxiety Disorder, and Depression. Review of the comprehensive care plan for Resident #18 revealed, .The resident uses antipsychotic medications date initiated [DATE] . Review of the Order Recap Report dated [DATE] revealed an order for Quetiapine Fumarate [antipsychotic medication given for behaviors] oral tablet 35 mg (milligram) given 0.5 tablet by mouth at bedtime for Depressive Disorder with a start date of [DATE] and end date of [DATE]. Review of the comprehensive care plan for Resident #18 revealed the care plan was not updated to reflect the antipsychotic medication had been discontinued. During an interview on [DATE] at 4:21 PM, the Minimum Data Set (MDS) Coordinator stated, .her [Resident #18] care plan does say use of antipsychotic. It should be updated . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure, Acute Kidney Failure, and Retention of Urine. Review of the comprehensive care plan for Resident #111 revealed, .The resident has Foley Catheter Urine Retention Date Initiated XXX[DATE] . Review of the Order Summary Report for Resident #111 revealed, .Indwelling catheter .Order Date XXX[DATE] .D/C [discontinue] foley XXX[DATE] . Review of the comprehensive care plan for Resident #111 revealed the care plan was not updated after the Foley Catheter was discontinued. During an interview on [DATE] at 4:21 PM, the MDS Coordinator stated, .he had the foley catheter upon admission the care plan should be updated . Review of the medical record revealed Resident #170 was admitted to the facility on [DATE] and discharged on [DATE] with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), Altered Mental Status, Cognitive Communication Deficit, and Type 2 Diabetes Mellitus with Diabetic Neuropathy. Review of the Quarterly MDS dated [DATE] revealed Resident #170 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated no cognitive impairment. Review of the facility investigation revealed on [DATE] at 4:48 PM, Resident #170 reported to her nurse that another resident (Resident #270) came into her room and hit her. Resident #170 reported Resident #270 swung an open hand at her and scratched the right side of her face. Both residents received a head-to-toe skin assessment with no visible bruises or other injuries noted. Both residents were immediately separated from one another. Review of the comprehensive care plan for Resident #170 revealed no interventions related to the resident-to-resident altercation on [DATE]. Review of the medical record revealed Resident #270 was admitted to the facility on [DATE] and discharged on [DATE] with a diagnoses which included Anxiety, Cognitive Communication Deficit, Adjustment Disorder with Disturbance of Conduct, and Dementia. Review of the MDS dated [DATE] revealed Resident #270 had a BIMS score of 4 which indicated severe cognitive impairment. Review of the facility investigation revealed on [DATE] at 1:30 PM, Resident #271 reported that his roommate Resident #270 had hit him over his head with a plate lid. A skin assessment was completed on Resident #271, and no bruises or marks were found. Resident #271 was immediately moved to another room on another wing. Family was notified, and Physician was made aware of incident. Review of the comprehensive care plan for Resident #270 revealed there was no revision to the plan of care following the physical alterations on [DATE] and [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #271 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Encounter for Orthopedic Aftercare following Surgical Amputation, Type 2 Diabetes Mellitus, Osteomyelitis, Acquired Absence of Right Leg Below Knee, Muscle Weakness, and Other Lack of Coordination. Review of the Admission MDS for Resident #271 dated [DATE] revealed a BIMS score of 15 which indicated no cognitive impairment. Review of the Comprehensive Care Plan for Resident #271 revealed appropriate interventions added. Resident #271 was switched to a different room on a different hall. During an interview on [DATE] at 11:23 AM, MDS Registered Nurse (RN) P was asked if a resident-to-resident altercation occurred should that be reflected on the care plan. MDS RN P stated, .yes .I would place something on the care plan for the staff to know the resident was abusive .It would be important to place that on the victims' care plan also . The MDS RN P was asked if Resident #170 and Resident #270's care plans were updated after the resident-to-resident altercation dated [DATE]. The MDS RN P reviewed the care plans and stated, .No . MDS RN P also confirmed that the resident-to-resident altercation that occurred on [DATE] between Resident #270 and #271 was not on Resident #270's care plan. Review of the medical record revealed Resident #175 was admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, History of Falling, Unsteadiness on Feet, and COPD. Review of the Progress Notes dated [DATE] revealed, .Resident told this nurse I fell from my wheelchair . Review of the Admission MDS dated [DATE] revealed Resident #175 had a BIMS score of 15 which indicated no cognitive impairment. Continued review of the MDS revealed Resident #175 required substantial/maximal assistance with sit to stand and chair/bed to chair transfer. Further review of the MDS revealed Resident #175 had a fall in the last month prior to admission and a fracture related to a fall in the last 6 months. Review of the comprehensive care plan revealed no revision to address the [DATE] fall. During an interview on [DATE] at 9:11 AM, Resident #175 stated, .I fell Saturday .once I was going to the wheelchair and the other time, I was going back to the bed . During an interview on [DATE] at 4:21 PM, the MDS Coordinator stated, .Ideally after a fall the floor nurse would put in an intervention to prevent further falls . During a telephone interview on [DATE] at 4:56 PM, RN LLL stated, .I was there the day [Named Resident #175] had a fall .I was across the hall giving medications, and I heard him yelling .I really didn't know how to update the care plan . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record revealed Resident #273 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses which included Encounter for Surgical Aftercare following Surgery on the digestive System, Type 2 Diabetes Mellitus without complications, Moderate Protein-Calorie Malnutrition, Diverticulosis of Intestine, Acute Kidney Failure, Personal History of other Malignant Neoplasm of Large Intestine, and Vascular Dementia. Resident #273 expired on [DATE]. Review of the comprehensive care plan revised [DATE] for Resident #273 revealed no focus related to hospice care initiated on [DATE]. Review of the Order Summary Report for Resident #273 revealed an order dated [DATE], .Admit to [Named Hospice Provider] end of life care . Review of the Quarterly MDS dated [DATE] revealed Resident #273 had a BIMS score of 3 which indicated severe cognitive impairment. During an interview on [DATE] at 10:33 AM, MDS Licensed Practical Nurse (LPN) TT was asked if Resident #273 was care planned for Hospice Services. MDS LPN TT confirmed Resident #273's comprehensive care plan did not address Hospice Services. 46252 46532

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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** 44724 Based on facility policy review, facility documentation, and interview, the facility failed to provide incontinence care for 6 of 31 (Residents #6, #40, #55, #99, #103, and #108) sampled residents reviewed for incontinence care. The findings include: Review of the facility policy titled, Activities of Daily Living (ADLs), with a revision date 2/12/2024 revealed, . The resident will receive assistance as needed to complete activities of daily living .Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice .and the residents ' choices .The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living . Hygiene-bathing, dressing, grooming .A resident who is unable to carry out activities of daily living receives the necessary services to maintain good .grooming, and personal .hygiene .Assist resident with bed/wheelchair repositioning as necessary to promote good body alignment and to prevent breakdown . Review of the facility policy titled, Resident Rights, with review date of 9/25/2023 revealed, .The resident has a right to a dignified existence .The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source . Review of the facility policy titled, Resident Call System, with review date of 1/15/2024 revealed, .The nurses' stations in the facility will be equipped to receive resident calls with a communication system through audible or visual signals from resident rooms, toilets, and bathing facilities .Facility associates should always be aware of call lights .The call light should not be deactivated until the need has been met . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis (a condition that can cause weakness or paralysis on one side of the body) following Cerebral Infarction affecting Dominate Right Side, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Quarterly MDS assessment dated [DATE] revealed Resident #6 had a BIMS score of 15 which indicated no cognitive impairment. Resident #6 required substantial/maximal assistance with toileting hygiene and frequently incontinent of bowel and bladder. During an interview on 8/13/2024 at 11:45 AM, Resident #6 was asked about care in the facility Resident #6 stated, the worst call light response times are at breakfast, lunch, and dinner and can take up to an hour at times for staff to respond. Resident #6 was asked how she knew how long it took for staff to answer the call light. Resident #6 stated, .I time it by my clock on the wall . Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses which included Fracture of Left Ilium, Muscle Weakness, Difficulty Walking, COPD, and Paroxysmal Atrial Fibrillation. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission MDS dated [DATE] revealed Resident #40 had a BIMS score of 13 which indicated no cognitive impairment. Resident #40 was incontinent of bowel, bladder, and required assistance with toileting and upper body dressing. During an interview on 8/21/2024 at 3:50 PM, Resident #40, stated, .it takes a long time for your call light to be answered especially during mealtimes .sometimes I lay in urine all night .I mean if I am going to need to stay wet, I would prefer to be in a swimming pool .can't get up and go to the bathroom without help .there is one CNA that will come in turn my light off say she is going to get help, and I always know she won't come back . Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Other Spondylosis with Myelopathy, Cervical Region, Displacement of Indwelling Ureteral Stent, Personal History of Transient Ischemic Attack (TIA), and Cerebral Infarction without Residual Deficit. Review of the Quarterly MDS dated [DATE], revealed Resident #55 had a BIMS score of 13 which indicated no cognitive impairment. Resident #55 required supervision to total assistance with Activities of Daily Living [ADL]s, and frequently incontinent of bowel and bladder. During an interview on 8/13/2024 at 11:40 AM, Resident #55 stated the call light response time can take from 30 minutes to an hour depending on the time of day and the staff will not change me during mealtimes. Resident #55 was asked how she knew how long it took for staff to respond to the call light. Resident #55 stated by the time on my cell phone and my roommate's big clock on the wall. Review of the medical record revealed Resident #99 admitted to the facility on [DATE] with diagnoses which included Hemiplegia and Hemiparesis following Nontraumatic Intracerebral Hemorrhage affecting Left Dominant Side, Asthma, and Acute Respiratory Failure with Hypoxia. Review of the MDS dated [DATE] revealed Resident #99 had a BIMS score of 15 which indicated no cognitive impairment. Resident #99 required substantial/maximal assistance with toileting and rolling left and right. During an interview on 8/19/2024 at 9:54 AM, Resident #99 stated, .the staff will come in answer the light and say I need to go get some help and then you don ' t see them again .the [Certified Nursing Assistant] CNAs will tell you I can't change you right now we are delivering trays .Monday I waited 3 hours to be changed I was wet and dirty .it was around breakfast time .I watched the clock . Review of the medical record revealed Resident #103 was admitted to the facility on [DATE], with diagnosis that included Aftercare following Joint Replacement Surgery, Type 2 Diabetes Mellitus, Chronic Pain Syndrome, and Muscle Weakness (generalized). Review of the Admission MDS assessment dated [DATE], revealed Resident #103 had a BIMS score of 15 which indicated no cognitive impairment. Resident #103 was incontinent of bladder and required supervision/total assistance with ADLs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hickory Woods	4200 Murfreesboro Pike Antioch, TN 37013

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/2024 at 2:55 PM, Resident #103 stated, .It takes 20 minutes or more for call lights to be answered . Resident #103 was asked for specific dates, times, and shifts that the call light was not being answered timely. Resident #103 stated, .It happens several times a week and is worse on evenings and weekends . Resident #103 was asked how she knows how long it takes for staff to answer the call light. Resident #103 stated, .I know because I time it with my cell phone, and I look at my roommates' clock on the wall, and I can time it by my 30-minute programs on TV . Resident #103 was asked about call light response during mealtimes. Resident #103 stated, .The techs [CNAs] will answer the call light and have told me that when trays are on the hall, they cannot change me . Review of the medical record revealed Resident #108 was admitted to the facility on [DATE] with diagnoses which included COPD, Acute and Chronic Respiratory Failure with Hypoxia, Type 2 Diabetes Mellitus, and Hypertensive Chronic Kidney Disease. Review of the Admission MDS dated [DATE] revealed Resident #108 had a BIMS score of 13 which indicated no cognitive impairment. Resident #108 required partial/moderate assistance with toileting, upper and lower body dressing, and personal hygiene. During an interview on 8/21/2024 at 10:58 AM, Resident #108 stated, .My roommate [Resident #40] had her light on for a long time because she was wet .I know she waited an hour and half. I watched the clock .it just seems like they don't have enough help .the CNAs will tell you when they are passing out meal trays they can't do anything else .I can take myself to the bathroom but one night around 6:00 PM or 7:00 PM, I was having difficulty pulling up my pull up [brief] .I had my light on, I was crying and screaming for help .I finally kept on trying and got it pulled up but I was so out of breath by the time I made it back to the bed it was awful because I have COPD . I don't understand why they can't assign someone during the meals to answer the call lights . During an interview on 8/21/2024 at 8:30 AM, CNA PP stated, .we are not allowed to change someone during meals we have to deliver trays first . During an interview on 8/21/2024 at 9:05 AM, Licensed Practical Nurse (LPN) D stated, .if the staff are passing trays one CNA would need to stop, change the resident .you would not put the resident off if they needed changing . During an interview on 8/21/2024 at 9:25 AM, CNA W stated, .if I was delivering trays, I would get another CNA to go change the resident if the resident was wet . During an interview on 8/22/2024 at 2:07 PM, the Administrator stated, I knew we had some issues with bathing. During an interview on 8/22/2024 at 4:38 PM, the Regional Registered Nurse stated, we schedule bathing 3 times per week, but regulations are 2 times per week. During an interview on 8/22/2024 at 2:07 PM, the Administrator was asked what the CNAs should do if resident needs assistance with toileting/incontinence care while meal trays were being served. The Administrator stated the resident should receive the needed care. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445507	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Hickory Woods	4200 Murfreesboro Pike Antioch, TN 37013

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/22/2024 at 5:35 PM, CNA BBB stated, .at mealtime .we can't change a resident during that time due to cross contamination .

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Hickory Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Murfreesboro Pike Antioch, TN 37013	

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46252 Based on facility policy review, medical record review, and interview, the facility failed to follow Medical Doctor's (MD) orders for 1 of 9 (Resident #275) sampled residents reviewed. The findings include: Review of the facility policy titled, Administration of Medications, revised 2/13/2023, revealed, .The facility will ensure medications are administered safely and appropriately per physician order to address residents' diagnoses and signs and symptoms .Staff who are responsible for medication administration will adhere to the 10 Rights of Medication Administration .Right Documentation .Medication administrations should be documented timely following the administration to the resident. Review of the facility policy titled, Nursing Documentation, issued 8/20/2019, revealed, .The medical record must reflect .the care and services provided across all disciplines . Review of the medical record revealed Resident #275 was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure, Pneumonia, Acute Kidney Failure, Acute Pulmonary Edema, Chronic Obstructive Pulmonary Disease, and Elevated [NAME] Blood Cell Count. Resident #273 was discharged to the hospital on 7/26/2023. Review of the Clinical Physician Orders for Resident #275 dated 7/10/2023, revealed, .CPAP [continuous positive airway pressure- a device used to ensure needed oxygen is delivered] on while sleeping/napping and off while awake .directions .every shift .Oxygen with CPAP: Pressure setting 10, Large and type of mask Full Face mask, liter of oxygen 3L/m [3 liters/minute], frequency of use at bedtime and prn [as needed] every shift . Review of the Admission Minimum Data Set (MDS) dated [DATE], revealed Resident #275 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated no cognitive impairment. Resident #273 received Oxygen therapy. Review of the Treatment Administration Record (TAR) for Resident #275 dated 7/1/2023 through 7/31/2023, revealed there was no documentation of administration of Oxygen with CPAP on 7/16/2023, 7/17/2023, 7/20/2023, 7/22/2023 and 7/23/2023 for dayshift, and CPAP on while sleeping/napping and off while awake every shift on 7/16/2023, 7/17/2023, 7/20/2023, 7/22/2023 and 7/23/2023 for dayshift. Review of the comprehensive care plan for Resident #275 revised on 7/25/2024, revealed, .Focus .CPAP O2 [Oxygen delivered by CPAP] COPD [Chronic Obstructive Pulmonary Disease] PNA [Pneumonia]Respiratory failure .Interventions .CPAP per MD order. Care and maintenance per facility staff . During an interview on 8/21/2024 at 4:00 PM, the Director of Nursing (DON) viewed the TAR for Resident #275 dated 7/1/2023 through 7/31/2023 and confirmed there was no documentation of administration of Oxygen with CPAP or removal on the following dates: 7/16/2023, 7/17/2023, 7/20/2023, 7/22/2023, and 7/23/2023, The DON stated, .The expectation is that medications and treatments are signed off immediately after administration by nursing staff .

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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 0697

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide safe, appropriate pain management for a resident who requires such services.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 44724

Based on facility policy review, medical record review, facility documentation, and interview, the facility failed to implement an effective pain management regimen for 1 of 6 (Resident #111) sampled residents reviewed for pain management.

The findings include:

Review of the facility policy titled, Pain Assessment and Management, with revision date 9/12/2023 revealed, .All residents will be assessed for pain indicators upon admission/readmission, quarterly and with any change in condition .The facility must ensure that pain management is provided to residents who require such services; consistent with professional standards of practice .and the residents ' goals and preferences . Identifying and using specific strategies for preventing or minimizing different levels or sources of pain or pain-related symptoms based on the resident-specific assessment, preferences and choices, a pertinent clinical rationale, and the resident's goals .

Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] with diagnoses which included Congestive Heart Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease, Stage 3, Presence of Automatic Cardiac Defibrillator, and Retention of Urine.

Review of the comprehensive care plan dated 7/29/2024, for Resident #111 revealed, .The resident is on pain medication therapy Opiod .[Opioid] .

Review of the Admission Minimum Data Set (MDS) dated [DATE] revealed Resident #111 had a Brief Interview for Mental Status (BIMS) score of 15 which indicated no cognitive impairment.

Review of the OT (Occupational Therapy) Evaluation and Plan of Treatment dated 7/24/2024 revealed, .Pain .Patient has pain that interferes/limits functional activity .Yes .Patient has pain that interferes with sleep .Yes . Patient verbalized pain .Is skilled therapy needed to address pain .Nursing to address .

Review of the OT Treatment Encounter Notes dated 7/25/2024 through 8/20/2024 revealed, .Pre-Tx [treatment] Is skill therapy needed to address pain .Nursing to address .

Review of the OT Therapy Progress Report dated 8/6/2024 revealed, .Remaining Impairments .pain .

Review of the PT (Physical Therapy) Evaluation and Plan of Treatment dated 7/24/2024 revealed, .Patient Goals: Return home with greatest independence and get this pain down .Potential for Achieving Rehab Goals: Good with pain mgmt [management] and consistent participation in skilled therapy .Patient has pain that interferes/limits functional activity .Yes .Patient verbalized pain .Is skill therapy needed to address pain . Yes .prior two week history of progressive weakness and falls with subsequent R [right] knee pain .Pt [patient] reports 9/10 [pain scale range of 1 being the lowest and 10 being the highest] pain with minimal RLE [right lower extremity] movement and weight bearing, pt [patient] unable to stand as he reports pain is intolerable .Pt requires skilled therapy, pain mgmt, and skilled nursing to reduce pain and restore mobility .

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the PT Therapy Progress Report dated 8/6/2024 revealed, .Pt.refuses to attempt standing or any other transfer secondary to pain . Review of the Progress Notes dated 8/6/2024 revealed, .Note Text: Resident and family participated in care plan meeting with IDT [Interdisciplinary Team] .Therapy is working on sitting up at edge of bed. Pain is a barrier that is limiting him at this time. Goal is to start standing and getting OOB [out of bed] . Review of the Medication Administration Record (MAR) dated 8/2024 revealed on 8/4/2024 Resident #111 had a pain scale of 7 (severe pain) out of 10. Resident #111 was given Tylenol 650 mg (milligram) 1 tablet. Continued review of the MAR revealed Resident #111 had not been given Tramadol since his admission but was given Tylenol two times on 8/4/2024 and 8/17/2024. Review of the Order Summary Report dated 8/23/2024 revealed, an order for Tramadol HCL (Hydrochloride) (pain medication used to relieve acute pain severe enough to require an opioid treatment) oral tablet 50 mg (milligram) give 1 tablet by mouth every 6 hours as needed for moderate - severe pain and Tylenol give 650 mg by mouth every 6 hours as needed for mild - moderate pain. During an interview on 8/21/2024 at 9:35 AM, Certified Nursing Assistant (CNA) PP stated, .[Named Resident #111] experiences pain every time you roll him and touch him .his legs hurt him really bad .he will tell me, I hate this part because it hurts so bad . During an interview on 8/21/2024 at 10:47 AM, Resident #111 stated, .I hurt so bad, they give me Tylenol but at home it took 4 tablets to help relieve my pain . During an interview on 8/21/2024 at 11:40 AM, Resident #111 stated, .My legs and knees hurt me. The nurses told me I couldn't take anything else but Tylenol. Therapy got me up twice this morning. I didn't get any pain meds [medications] this morning . Resident #111 was asked if pain limits his ability to perform in his therapy and [Resident #111] stated, .Pain stops a whole lot of things from happening . During an interview on 8/21/2024 at 12:02 PM, Physical Therapist (PT) BB was asked about the pain Resident #111 was experiencing during his therapy. PT BB stated, .we have been battling this for a while Tylenol only given when he asks for the medication .I went to nursing, I have wrote a note .I am not sure it is being communicated .it is hindering him progressing .his pain is with movement .I spoke to one nurse . sometimes we have to stop therapy .he lets us know when he is experiencing pain .standing hurts him bad I know it has been on 3 separate occasions he said I can't do it .It would help him if he had routine pain medication or given pain medication 30 minutes prior to his therapy . PT BB was asked if he had ever spoken to the Director of Nursing in regards to his pain control, he stated, No. During an interview on 8/21/2024 at 12:20 PM, the Director of Nursing (DON) was asked if a resident voiced in a care plan meeting that pain is barrier for him, what would she expect staff to do. The DON stated, . definitely look at pain management .If he expressed, he was having pain I expect the Tramadol to be given . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Life Care Center of Hickory Woods		STREET ADDRESS, CITY, STATE, ZIP CODE: 4200 Murfreesboro Pike Antioch, TN 37013	

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/21/2024 at 12:30 PM, Licensed Practical Nurse (LPN) D stated, .He [Named Resident #111] has told me a couple of times he was hurting. I will usually ask him if he is having pain. I never know what time he is going to go to therapy. It would be helpful for me to have a list of the times . LPN D was asked if she was notified that Resident #111 voiced in the care plan meeting 8/6/2024 that pain was a barrier for him. LPN D stated, .I wasn't notified .If I had known I could have tried to get the pain medication scheduled with his routine medications .I don't know why the Tramadol hasn't been given . During an interview on 8/22/2024 at 2:07 PM, the Administrator stated, .If a resident communicated the pain to therapy, I would expect them to follow up .If I was a therapist and I told the nurse today about his pain, I would expect the therapist to go above the nurse and speak to administration .

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F 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 46252

Based on facility policy review, medical record review, facility document review, and interview the facility failed to provide pharmaceutical services policies and procedures that ensured the dispensing and disposition (possession or control of medication) of physician ordered medications to meet the needs of each resident in 1 of 1 (Resident #275) sampled resident reviewed for taking medications brought in from home by a family member.

The findings include:

Review of the facility policy titled, MEDICATIONS BROUGHT TO NURSING CARE CENTER BY RESIDENT OR RESPONSIBLE PARTY, dated 1/2023, revealed, .Medications brought into the nursing care center by a resident or responsible party are accepted only with a current order by the resident's prescriber, after the contents are verified by the nurse, and if packaging meets the state, federal and pharmacy's guidelines .Use of the medications brought to the nursing care center by a resident or responsible party is allowed only when the following conditions are met and is allowed per state regulation .The medication name, dosage form, and strength has been verified by the nurse accepting the medication .

Review of the medical record revealed Resident #276 was admitted to the facility on [DATE] with diagnoses which included Aftercare following Explantation (removal) of Hip Joint Prosthesis, Hepatic Encephalopathy, Other Cirrhosis of Liver, Bacterial Infection, and Acute Kidney Failure, unspecified. Resident #276 was discharged from the facility on 1/10/2024 to the acute care hospital.

Review of the Order Summary Report for Resident #276 dated 1/2/2024, revealed, .rifaximin Oral Tablet 550 MG [milligram] (Rifaximin) give 1 tablet by mouth two times a day for Cirrhosis .Order Dated 1/2/2024 .

Review of the Admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #276 had a Brief Interview for Mental Status (BIMS) score of 9 which indicated moderate cognitive impairment.

Review of the Progress Notes for Resident #276 dated 1/2/2024 through 1/9/2024, revealed, no documentation of receipt of any physician ordered medication brought into the facility by a family member, no documentation of nurse accepting or verifying medication brought into the facility by a family member, and no documentation of disposition of physician ordered medication brought into the facility by a family member after Resident #276 was discharged on [DATE].

Review of the Medication Administration Record (MAR) for Resident #276 dated 1/1/2024 through 1/31/2024, revealed, .rifaximin Oral Tablet 550 MG [Milligram] (Rifaximin) Give 1 tablet by mouth two times a day for Cirrhosis - Order Date 1/2/2024 1408 [2:08PM]- D/C [Discontinue] Date - 1/11/2024 0748 [7:48 AM] . Nursing documentation on 1/2/2024 through 1/5/2024 revealed medication was not administered as per physicians order.

Review of the facility document titled, RETURNS/DISCARDS AUDIT REPORT, dated 1/1/2024 through 3/31/2024, revealed, no documentation Rifaximin 550 MG was returned to the pharmacy.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled, Drop-Box Drop Record, dated 1/3/2023, 2/9/2023, 3/2/2023, 3/12/2023, and 3/19/2023, revealed no documentation Rifaximin 550 MG tablet was returned to the pharmacy for Resident #276. During an interview on 8/13/2024 at 10:45 AM, Licensed Practical Nurse (LPN) D was asked about the procedure when a family member brings in a physician ordered medication from home. LPN D stated when a family member brings in physician ordered medications from home the medication has to be in the original bottle and untouched. The medication is then locked in the medication cart and documented when administered on the MAR. LPN D was asked about disposition of medications brought from home when a resident goes to the hospital or is discharged . LPN D stated if the resident is returning to the facility the medication is kept in the locked medication cart. If the resident is discharged the family is called and asked to pick up the medication. LPN D was asked about documentation of medication receipt and disposition of the medication. LPN D stated the facility did not have a procedure or form to document receipt or disposition of medications brought into the facility from home. During an interview on 8/13/2024 at 11:37 AM, LPN J was asked about disposition of physician ordered medications brought into the facility from home. LPN J stated the medication is kept in the locked medication cart and documented as administered on the MAR. When the resident is discharged , the medication is sent home with the family. LPN J was asked about disposition of physician ordered medications from the pharmacy when a resident is discharged . LPN J stated it is sent back to the pharmacy. LPN J was asked what happens if medication not obtained from the pharmacy are sent back to the pharmacy. LPN J stated the pharmacy would send the medication back to the facility. During a phone interview on 8/13/2024 at 12:45 PM, the Pharmacy Representative was asked if the facility returned a resident's personal medication brought from home to the pharmacy what would happen to the medication. The Pharmacy Representative stated that the pharmacy does not accept personal resident medications that were not dispensed by the pharmacy. If received the medication would be returned to the facility. When asked if there was a chain of custody on the receipt and return to facility of medications not filled by the pharmacy the Pharmacy Representative stated, No, we would call the facility and tell them we are sending it back if we got something we did not dispense. If the medication was not dispensed by [named pharmacy] we would not have any knowledge of it. When asked if there was a policy or procedure for tracking the receipt and disposition of physician ordered medications brought into the facility by residents or resident representatives. The Pharmacy Representative stated, the pharmacy has a Returns/Discards Audit Report for tracking medications dispensed and returned to the pharmacy. The facility should have a policy or procedure in place for tracking physician ordered medications brought into the facility by other sources. During a phone interview on 8/13/2024 at 4:12 PM, Family Member OO stated she was asked by the facility to bring in Resident #276's physician ordered medication Xifaxin (rifaximin). Family Member OO stated, the facility told her it had to be an unopened full bottle of medication with pharmacy label on it. Family Member OO stated, .I brought one bottle of the medication Xifaxin to the facility on Saturday 1/6/2024. I asked the nurse for a receipt the nurse stated it was not necessary .I went to the facility to pick up the medication a few days after he (Resident #276) was admitted to the hospital and was told the medication could not be located. I never received the medication after his [Resident #276] discharge . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/2024 at 4:59 PM, Registered Nurse (RN) H stated, Resident #276's family had brought a physician ordered medication in from home, and stated the medication was picked up by the family member with Resident #276's belongings after Resident #276 was discharged to the hospital. There was no documentation of receipt of a physician ordered medication brought in by a family member to the facility in Resident #276's medical record. There was no documentation Resident #276's family member received a physician ordered medication brought to the facility after Resident #276's discharge. During an interview on 8/13/2024 at 5:25 PM, The Administrator was asked for a policy and/or procedure for tracking physician ordered medications brought into the facility by a resident's family. The Administrator stated, there was no facility policy or procedure in place on tracking the receipt and disposition of physician ordered medications brought into the facility for residents from family members. During a phone interview on 8/15/2024 at 12:15 PM, the Medical Director was asked about the policy and procedure for tracking physician ordered medications brought into the facility for residents by family members. The Medical Director stated, I don't know the exact procedure for medications being brought in from home. I approve or disapprove the medication. The Medical Director was asked would you expect medication brought in from home to have a chain of custody? The Medical Director stated, Yes, someone should be tracking the medication. I would expect the facility to have a policy or procedure in place for tracking medications brought into the facility from home.

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Hickory Woods		STREET ADDRESS, CITY, STATE, ZIP CODE 4200 Murfreesboro Pike Antioch, TN 37013	

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 44724 Based on facility policy, observation, and interview the facility failed to maintain a resident call system to allow a resident or resident representative to call for staff assistance through a communication system which relays the call directly to a centralized staff work area for 1 of 31 (Resident #105) sampled residents reviewed. The findings include: Review of the facility's policy titled, Resident Call System, revised on 1/4/2023, revealed, .The nurses' stations in the facility will be equipped to receive resident calls with a communication system through audible or visual signals from resident rooms .The call light should be positioned in reach of the resident .The call system must be accessible to residents while in their bed or other sleeping accommodations within the resident's room .In the event that the nurse call system becomes inoperable .Director of Maintenance .should be called immediately if there is a malfunction of any portion of the system . Observation in Resident #105's room on 8/20/2024 at 10:15 AM, the call light was without a cord for the resident or resident representative to use if needed. During an observation and interview in Resident #105's room on 8/20/2024 at 10:27 AM, Licensed Practical Nurse D stated, .It looks like the call light is on the floor and maybe broken . LPN D was asked to get the Maintenance Director. An unnamed Certified Nursing assistant walked into Resident #105's room moved the bed and found the call light cord on the floor with the connecting wires hanging out of the end. During an observation and interview in Resident #105's room on 8/20/2024 at 10:32 AM, the Maintenance Director stated, .I was not aware of the broken call light .