STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445508	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Obion County Nursing Home	1084 East County Home Road Union City, TN 38261

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, facility video review, facility investigation review, observation, and interview, the facility failed to ensure staff followed the facility policy for a resident transfer and assessment of an injury after a transfer for 1 of 3 (Resident #1) sampled residents reviewed for accident hazards. On 6/11/2025, Resident #1, a cognitively impaired vulnerable resident, who required 2-person assistance with transfers, was transferred from the bed into the shower chair, and from the shower chair into the wheelchair, using her arms instead of the mechanical lift, by 2 Certified Nursing Assistants (CNA) A and B. Approximately 3 hours later, CNA B reported the injury to Licensed Practical Nurse (LPN) F, who was observed to assess Resident #1's injury on facility video footage, and failed to report the incident to Administration or document the assessment. The failure of the facility staff to transfer Resident #1 according to the facility policy resulted in actual Harm to the Resident when Resident #1 sustained a Right Humerus fracture (broken bone in the upper arm). The findings include: 1. Review of the facility policy titled, Safe Resident Handling/Transfers/Mechanical Lift, dated 1/1/2025, revealed .It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury .in accordance with current standards and guidelines .Two staff members must be utilized when transferring residents with a mechanical lift .Staff members are expected to maintain compliance with safe handling/transfer practices .Failure to maintain compliance may lead to disciplinary action up to and including termination of employment .Resident lifting and transferring will be performed according to the resident's individual plan of care . Review of the facility policy titled, Unexplained Injuries dated 11/21/2024, revealed .All unexplained injuries . relevant information shall be documented in the resident's medical record including .Physical assessment findings, including objective descriptions of the injury . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Gastrostomy (surgically created opening in the abdominal wall, leading directly into the stomach, used for administering medications and/or feedings), Chronic Pulmonary Edema, and Hemiplegia of Right Side. Review of the Significant Change MDS dated [DATE], revealed Resident #1's cognitive skills for daily decision making were severely impaired. Resident #1 was dependent on staff for all Activities of Daily Living (ADLs) and required a mechanical lift for transfers. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Care Plan for Resident #1 dated 4/18/2025, revealed .The resident has an ADL self-care performance deficit r/t [related to] Confusion, Dementia, Impaired balance .TRANSFER: The resident requires [named mechanical lift] LIFT WITH 2 PEOPLE PRESENT FOR assistance for transfers . Review of the facility video footage dated 6/11/2025 at 2:37 PM, revealed CNA A with a lift pad over her arm pushed Resident #1's empty wheelchair into the Whirlpool Room. Review of the facility video dated 6/11/2025 at 2:43 PM, revealed CNA A and CNA B took an empty shower chair into Resident #1's room. Review of the facility video dated 6/11/2025 at 2:46 PM, revealed CNA A pushed Resident #1 into the Whirlpool Room in the shower chair. Review of the facility video dated 6/11/2025 at 2:49 PM, revealed CNA B entered the Whirlpool Room. Review of the facility video dated 6/11/2025 at 2:56 PM, revealed CNA A exited the Whirlpool Room and pushed Resident #1 in a wheelchair toward Resident #1's room. Review of the facility video dated 6/11/2025 at 5:40 PM, revealed CNA B pushed Resident #1's wheelchair to the Nurse's Station and began to talk to LPN F. At approximately 5:42 PM, CNA B and LPN F walked to Resident #1 who was sitting in the wheelchair. LPN F bent over the right side of Resident #1 for approximately 1 minute, looking at Resident #1's right arm and talking to CNA B, then CNA B and LPN F walked away in different directions. Review of the facility investigation dated 6/12/2025 at 11:30 AM, revealed CNA (CNA C) reported Resident #1's (right) arm was swollen to the charge nurse (LPN G) on 6/12/2025 at approximately 11:30 AM. The Medical Director (MD) was notified and gave an order to obtain an x-ray of Resident #1's arm. On 6/12/2025 at approximately 3:30 PM, the preliminary radiology report revealed a fracture of the humerus. The appropriate parties were notified, and an investigation was begun. Review of the facility investigation dated 6/13/2025, revealed .About 1:30 pm [PM], Chatter on the floor stated [the] incident happened on 6/11/2025 at around 2:45 pm. During a repositioning of a resident [Resident #1] in the shower room, 2 cnas [CNA A and CNA B] lift [lifted] the resident by grabbing her arms on each side and pulled her up in the chair. At this point it was reported they heard a pop. They did not report [the pop] at this time. At 5:40 pm 1 of the cnas [CNA B] report [reported] to the charge nurse [LPN F] who could be seen on camera assessing the residents [resident's] arm. They decide [decided] not to tell anyone about the incident. When questioned at 2:00pm on 6/13/2025, they all [CNA A, CNA B, and LPN F] deny the incident. When told it's on camera they continue to deny. At this point these 3 employees [CNA A, CNA B, and LPN F] were termed [employment was terminated] and immediately left the building. Resident [#1] went to ortho [orthopedic doctor] on 6/13/2025. Arm [right] placed in cast and weekly follow ups with Ortho scheduled . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of a Nurses' Note for Resident #1 dated 6/12/2025 at 5:45 AM, revealed .LATE NOTE .Resident up in wheelchair in day room when I [LPN G] arrived at facility .Resident was placed in her room and laid down approximately 1130 [11:30 AM on 6/12/2025] .[CNA B] came to me and explained that [Resident #1] arm looked floppy. I immediately went to resident's [Resident #1's] room and examined arm. Swelling and bruising noted toLUE [to Left Upper Extremity]. Resident was guarding arm. I went to ADON's [Assistant Director of Nursing] office and reported findings immediately after examination and called MD [Medical Director] for X RAY orders. X ray performed .ADON notified. The facility investigation revealed CNA C reported the injury to Resident #1's arm on 6/12/2025 at approximately 11:30 AM. Review of the written statement by CNA A dated 6/12/2025, revealed .I had [CNA B] help me transfer [Named Resident] on 6/11/2025 for a shower .we .lifted her to the shower chair and [CNA B] helped me transfer her back to her wheelchair after me giving her a shower . Review of the written statement by CNA C dated 6/12/2025, revealed CNA C observed a bruise and swelling to the inside of Resident #1's elbow at approximately 11:00 to 11:30 AM, and reported the bruising to LPN G. Review of the Incident Report for Resident #1 dated 6/12/2025 at 11:30 AM, revealed .CNA .noticed that resident's arm was swollen and bruised stating it was floppy .Nurse .assessed resident's right arm. Arm was noticeably swollen with bruising located in the bend of patient's arm .MD notified with order to obtain an x-ray . Review of a Radiology Report dated 6/12/2025, revealed .Acute mildly displaced [bones are out of alignment or in pieces] comminuted fracture [where the bone breaks into 3 or more pieces] of the distal humerus .Mild degree of osteopenia [loss of bone density] . Review of the Physician's Note dated 6/13/2025 (no time recorded), revealed .fracture of the humorous [humerus] .Appointment arranged for .orthopedic surgeon. Review of the Orthopedic Progress Note dated 6/13/2025, revealed .recommended .a cast .long-arm fiberglass cast was put on .will follow up in the office in 1 week for reevaluation .will remove the cast .to evaluate for any evidence of skin breakdown . Review of the written statement by CNA D dated 6/13/2025, revealed .CNA C approached me and asked if I had heard about [Resident #1's] arm being broke .tell [told] me that it happened during a transfer by 2 CNA's on second shift and that her [CNA C's] mother [LPN F] was on shift at this time .stated [LPN F] didn't want the CNA's [CNA A and B] to lose their job, so she [LPN F] failed to report the incident . Review of the written statement by the Administrative Assistant dated 6/13/2025, revealed .I was in the administrator's office as a witness during questioning between the Administrator and [CNA B] .when asked how [Named Resident #1] was transferred, [CNA B] said with 2 people and a lift pad .stated they did not use the [named mechanical lift] but did use the lift pad to transfer .[CNA B] became upset when questioned . When asked if she said anything to [Named LPN F], [CNA B] said yes .When the video was mentioned to [CNA B] she started crying .said I was afraid for my job, I've got one toenail keeping me here and I got scared .[Named LPN F] said she wouldn't say anything if I didn't . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the written statement by CNA E on 6/16/2025, revealed .a coworker [CNA B] came up to me and told me she is being ate [eaten] up with guilt .her and another co-worker [CNA A] were lifting a resident when they hear a pop in her arm .They looked at each other and went on their way .[CNA B] told me she was going to tell her charge nurse [LPN F] .came back and said that the nurse [LPN F] said not to say anything . [CNA B] told me she was then going to text the ADON [Assistant Director of Nursing] about the situation . Observation in the Resident's room on 6/25/2026 at 9:41 AM, revealed Resident #1 seated in a [Named wheelchair] with her right arm wrapped in gauze from her wrist to right below her elbow. Observation in the Resident's room on 6/25/2025 at 4:40 PM, revealed Resident #1 seated in a [Named wheelchair]. Resident #1 pulled and unwound the gauze wrapped around her right arm leaving the splint on her arm uncovered from her wrist to her forearm. During a telephone interview on 6/25/2025 at 2:07 PM, CNA B stated .Another coworker [LPN B] was coming in with the Resident [Resident #1] and asked if I would help transfer her to the shower chair .We used the [named mechanical lift] to put her on her chair .then I went back to my job .I don't know how she got back to the wheelchair from the shower chair .came back into the shower .she [Resident #1] was already in her wheelchair .was kinda [kind of] sitting back to the side .I got on her good side and grabbed both loops [of the lift pad] on my side to reposition her .I wasn't paying attention, not sure what she [CNA A] got a hold on .saw her [Resident #1] later at the nurse's station .wasn't acting like herself .notified the nurse, told her that [Resident #1] is not herself since shower .[LPN F] asked me to take her to her room, [LPN F] looked [at Resident #1's arm] said she [Resident #1] looks fine to me .She [LPN F] said .not going to say anything .if she gets to crying out or something I will get her vitals. Review of the video footage did not corroborate the mechanical lift was taken in Resident #1's room. During a telephone interview on 6/25/2025 at 3:25 PM, CNA A was asked if Resident #1 was transferred with a (mechanical) lift to and from the shower chair. CNA A stated .No, I didn't use one to put her into the shower chair .Got up under her arms and pivoted on her good foot .didn't use the [named mechanical] lift except her getting back into the bed later .Another aide [CNA B] helped me get her out of the bed .helped me to get her into the shower chair .clean and dry lift pad was in the wheelchair .she was care planned for the [named mechanical] lift .anytime we got her in the wheelchair we used the [named mechanical lift] .Always need 2 people for the [named mechanical lift] .We sat her on the side of the bed and two personed her [2 person assist] into the shower chair .same aide [CNA B] helped me get her from the shower chair to the wheelchair . CNA A was asked if the [named mechanical lift] should have been used for the resident transfer. CNA stated . Yes ma'am we should have used the lift . During a telephone interview on 6/26/2025 at 1:11 PM, LPN F was asked if she knew anything about what had happened to injure the Resident (Resident #1). LPN F stated .I really don't have anything to add to what I already told the Administrator .She [Administrator] said I was on camera .all it showed was them [Resident #1 and CNA B] coming up to me .I don't even remember .She [Administrator] said I was examining her [Resident #1] arm .I don't remember her [CNA B] reporting any problem .That is something you would remember .I would have notified the Administrator if I had known .I don't remember anyone coming to me and asking me not to say anything . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 6/26/2025 at 9:11 AM, the ADON stated .[CNA B] said [to other staff members] she was going to talk to me about it [hearing a pop when transferring Resident #1] but she never came to me .I called her [CNA B] before she came in [for the interview] .told her she needed to be honest I was interviewing [LPN F] and [CNA C] walked in right after [LPN F] left .[CNA A] said [CNA B] had told [CNA C] they were trying to figure out a way to fix the problem . During an interview on 6/26/2025 at 10:14 AM, CNA C stated .[On 6/12/2025] I pulled her [Resident #1's] sleeve down, noticed that it looked swollen .like jelly .bruised .went and got [LPN G] .[LPN G] went to examine her .they did an x-ray found out it was broke .at this point I had no idea how it had happened .I talked to [CNA B] and she said she reported it [Resident #1's arm] to [LPN F] .[LPN F] told me she didn't want [CNA A and CNA B] to lose their jobs . During an interview on 6/26/2025 at 10:58 AM, CNA D stated .I was off the day it [Resident #1's fracture] happened .came back to work that Friday [6/13/2025] .[CNA C] asked me if I had heard about [Resident #1]'s arm being broke .said she was told that 2 CNA's were transferring [Resident #1] .one of the CNA's said [Resident #1]'s arm popped and they reported it to [LPN F] .but she didn't want them to lose their jobs .I [said] you've got to call [LPN F] and tell her she needs to report it .tell the truth . During an interview on 6/26/2025 at 3:14 PM, CNA F stated .during supper [CNA B] came up to me .said she felt really bad .something was wrong with [Resident #1] .said she heard a pop when her and [CNA A] were lifting her .she told me she felt guilty .said she was going to tell the charge nurse .later on she came back and told me the charge nurse told her not to say anything, not to say anything about it .She told me she was going to contact .[the] ADON .I was here .I heard everything first hand .from [CNA B] . CNA F confirmed that Resident #1 was care planned for a [named mechanical lift] lift and that 2 staff were required for transfers with the lift. During an interview on 6/26/2025 at 5:00 PM, the Administrator stated, .We found out about [about Resident #1's fractured humerus] 3:30 [PM] on Thursday afternoon [6/12/2025] .that's when the first x-ray report came in .We immediately got our Activities Director to start interviewing for any report of any employee, no complaint from residents .started questioning staff and getting statements. During all that time was thinking it [Resident #1's fractured humerus] was from where they were pulling her up in the chair or maybe the lift had hit the wheelchair arm .we kept questioning all through the night into the next morning .until about 1:30 [PM 6/13/2025], started hearing chatter from the staff that these 3 [CNA A, CNA B, and LPN F] were involved . she [CNA A] told me they had lifted her [Resident #1] up and put her in her chair, she was fine, that's all she gave me out of that situation, just they had transferred her. Went ahead and told her that wasn't what I was hearing and this was her chance to tell me the truth .she stuck to her story .I let her leave at that time .I got [Named LPN F] and did the same thing, told her I knew what happened before she even started telling me her story .she told us she never assessed or laid eyes on her [Resident #1] I told her what I saw on camera and she said it wasn't me .she watched a short segment .she left .called [Named CNA B] in, she didn't really admit [to anything], she said eventually she had the charge nurse look at her [Resident #1's] arm because she wasn't acting right .she denied anything else. [CNA B said] We didn't hear a pop or anything .before we [Administration] had ever even mentioned a 'pop', that was out of the blue .termed her right then .I had [Named ADON] call [CNA A] to let her know we had statements and videos and that she was termed . The Administrator confirmed that Resident #1 was harmed due to the actions of CNA A and CNA B, and that LPN F should have immediately reported the incident to the DON or to the Administrator.