STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445509	A. Building B. Wing	10/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Old Hickory Village	1250 Robinson Road Old Hickory, TN 37138

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility policy review, medical record review, and interview, the facility failed to facilitate the residents' and/or resident representatives' participation in the care planning process for 3 of 3 (Resident #1, Resident #3 and Resident #4) sampled residents reviewed for care planning conferences. The findings include: 1. Review of the facility policy titled, Comprehensive Care Plans and Conferences, dated 8/29/2025, revealed .The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident representative.in developing the care plan and making decisions about his or her care.The facility has a responsibility to assist residents to engage in the care planning process.holding care planning meetings at the time of day when the resident is functioning best.encouraging a resident's representative to participate in care planning and attend care planning conferences.each resident has the right to participate in choosing treatment options and must be given the opportunity to participate in the development, review and revision of his/her care plan.The resident's care plan must be reviewed after each assessment. 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Anxiety, Unspecified Blindness of One Eye, and Repeated Falls. Review of the Care Plan dated 3/29/2023, revealed, .frequent falls, difficulty walking. An intervention dated 4/10/2024, revealed, .Increase supervision to every 30 minutes when patient goes to bed until she gets up again. An intervention dated 8/01/2024, revealed .Care in Pairs . An intervention dated 12/26/2024, revealed .Redirect resident from bedroom to dayroom or nurses' station when up in w/c for monitoring. 3. Review of medical record revealed Resident #3 was admitted to the facility on [DATE] with a readmission on [DATE], with diagnoses including Traumatic Brain Dysfunction, Progressive Neurological Conditions and Hip and Knee Replacement. Review of the Care Plan dated 1/30/2025, revealed .impaired cognitive ability/impaired thought processes r/t [related to] Dementia.at risk for falls due to impaired mobility and weakness.at risk for change in mood or behavior.at risk for unavoidable pressure injury development or decline of skin integrity. Review of Care Conference Meeting notes dated 2/4/2025, revealed the daughter attended Resident #3's care conference meeting. Review of the significant change in condition MDS dated [DATE], revealed Resident #3 scored a 2 on the BIMS assessment, which indicated Resident #3 was severely cognitively impaired. There facility was unable to provide quarterly Care Conference Meeting notes for 4/24/2025 and 5/2/2025. 4. Review of medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Vascular Dementia and Diabetes. Review of the quarterly MDS dated [DATE], revealed Resident #4 scored a 3 on the BIMS assessment, which indicated Resident #4 was severely cognitively impaired. Review of the Care Plan dated 9/19/2025, revealed, .At risk for elopement [4/4/2025] .Add resident to the Elopement Book.Frequent monitoring q [every] 15min checks X [times] 72 hours.has impaired cognitive ability/impaired thought processes r/t [related to] vascular dementia. During a phone interview on 10/8/2025 at 1:04 PM, Family Member U of Resident #4 was asked what was discussed in Resident #4's Care Plan meetings following the alleged elopement. The family member stated she had not participated in Care Plan meetings related to Resident #4. During an interview on 10/9/2025 at 3:35PM, the Social Service Director (SSD) was asked how often care conference meetings were conducted for Long Term Care residents. The SSD stated, .I try to have the care plan meetings done within 72-hours of admission. and as needed or if family requests them . During an interview on 10/9/2025 at 6:10 PM, the Director of Nursing (DON) was asked how often should care plan conferences be conducted. The DON stated, .at admission, quarterly or if there has been a significant change in condition. The DON was asked if care conference meetings were being conducted. The DON stated, .I assumed they had not been being done since they cannot find any care conference meeting notes .

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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 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. (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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to identify accident hazards to prevent falls and failed to ensure safety during care for 1 of 3 (Resident #1) sampled residents reviewed for accidents. Resident #1 had moderately impaired cognition, was dependent upon staff for assistance with transfers, and used a wheelchair for mobility. On 4/4/2025, Resident #1 had an unwitnessed fall. Certified Nurse Assistant (CNA) O discovered Resident #1 on the floor with her right arm lodged in the wheel of the wheelchair. CNA O pulled Resident #1's right arm out of the wheel and Resident #1 sustained a large avulsion wound (a traumatic injury where the skin and other underlying tissues are torn away from the body, can cause heavy bleeding and require immediate medical care) to the right arm that required a hospital transfer and surgical repair, which resulted in actual HARM to Resident #1. The findings include: 1. Review of the facility policy titled, .Incident and Reportable Event Management, dated 9/23/2025, revealed .The facility to the best of its ability strives to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents .Accidents refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident . Avoidable Accident means that an accident occurred because the facility failed to .Identify environmental hazards and or assess individual resident risk of an accident . Evaluate/analyze the hazards and risk and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible .Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident .Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice .The licensed nurse should evaluate the resident and render first aide if needed .The nurse evaluation should be completed prior to moving a resident who has fallen to determine presence of injury . Review of the facility policy titled, Fall Management, dated 9/25/2025, revealed .The facility must ensure that.The environment remains free of accident hazards as is possible .Each resident receives adequate supervision and assistance device to prevent accidents. Fall-Refers to unintentionally coming to rest on the ground, floor or other lower level.Residents will be assessed for fall indicators, upon admission, readmission, quarterly, change in condition .Adequate Supervision is determined by assessing the appropriate level and number of staff required, the competency and training of staff, and the frequency of supervision needed. This is determined on the individual resident's assessed needs and identified hazards in the resident environment .Hazards-Refers to elements of the resident environment that have the potential to cause injury or illness .Hazards over which the facility has control .are those hazards in the resident environment where reasonable efforts by facility could influence the risk for resulting injury or illness .The intervention to reduce the risk of falls should be individualized based on the residents risk factor and fall history . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses including Anxiety, Unspecified Blindness of One Eye, and Repeated Falls. Review of the Care Plan dated 3/29/2023, revealed .frequent falls, difficulty walking.hx [history] right hip contusion [bruise] and hx left hx [as written on care plan] fracture with prothesis .poor safety awareness. Interdisciplinary team to meet as needed to discuss resident's condition and interventions.ADL [Activity of Daily Living] Assistance and Therapy Services needed to maintain or attain highest level of function . The care plan revealed the following revised interventions: On 12/21/2023, .STAFF EDUCATION WHEN PT. [PATIENT/Resident #1] IS UP AND RESTLESS IN W/C [wheelchair]. STAFF WILL MONITOR CLOSELY UNTIL PT. IS AT REST INERVENE AS INDICATED . On1/6/2024, .Not to be left in room unattended when up in w/c . On 2/2/2024, .Transfers extensive X [times] 1 . On 2/23/2024, .PT TO NURSING STATION FOR CLOSE MONITORING. On 3/19/2024, .Provide light when pt. is in bed monitor frequently. On 4/10/2024, . Increase supervision to every 30 minutes when patient goes to bed until she gets up again. On 8/01/2024, . Care in Pairs . On12/26/2024, .Redirect resident from bedroom to dayroom or nurses' station when up in w/c for monitoring. Review of the facility investigation titled, Risk Management Follow Up Packet, dated 2/1/2025, revealed CNA called nurse to help with the resident in the bathroom. Resident says she was trying to get in her chair and she missed the chair and fell out on her right hip Review of the Care Plan dated 2/1/2025, revealed , unwitnessed fall, do fall huddle after each fall to work root cause analysis PT NOT TO BE LEFT