STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445519	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Place Sumner	140 Thorne Boulevard Gallatin, TN 37066

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, record review, facility document review, and facility policy review, the facility failed to provide the required level of assistance with eating for 1 (Resident #70) of 3 residents reviewed for activities of daily living care. Findings included: An undated facility policy titled, Activities of Daily Living (ADL), Supporting, indicated, Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The policy further indicated, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, which included, d. dining (meals and snacks). An undated facility document titled, Meal Assist Levels, indicated, Use the following guidelines to ensure that each patient receives the appropriate level of assistance. The policy further revealed, YELLOW-Patient requires intermittent supervision with meals with verbal cues for initiation, attention to task, encouragement to increase intake and/or safe swallowing strategies. RED-Patient will need physical assistance with meals from minimal to total assist. Patient does not receive meal until staff is able to assist. Patient is not to be unattended until meal is completed. The policy revealed, The assist level will be indicated on the meal ticket above the patient's name listed on the bottom of the form. A Resident Face Sheet revealed the facility admitted Resident #70 on 12/12/2022. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of adult failure to thrive, dysphagia (difficulty swallowing); gastro-esophageal reflux disease (a stomach disorder that allows stomach acid and contents to back up into the esophagus); and unspecified, protein-calorie malnutrition. A significant change in status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/04/2026, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS indicated that the resident required partial to moderate assistance with eating. Resident #70's Care Plan included a problem area revised 02/09/2026, that indicated the resident had a limited ability to perform self-care related to weakness, difficulty walking, cognitive impairment, and hospice care. Interventions directed staff to set up meals and assist as needed (initiated 12/12/2022). Resident #70's occupational therapy progress note, dated 05/08/2025, indicated the resident required increased assistance at that time for meals by mouth and that the resident was changed to RED level assist at that time. Resident #70's View Dietary Order record included an order, with a start date of 05/08/2025 and a stop date of 06/16/2025, that indicated a Heart Healthy diet. The record revealed the Consistency specified mechanical chopped meat. Per the record, Special Instructions indicated, RED Level Assist. Resident #70's View Dietary Order record included a current order, with a start date of 06/16/2025, that indicated a Heart Healthy diet. The record revealed the Consistency specified mechanical ground meat. Per the record, Special Instructions indicated, RED level assist. During an observation on 03/16/2026 at 11:40 AM, Resident #70 was in bed, feeding themself lunch, without assistance. No staff were present in the resident's room. Resident #70's (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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lunch meal card, dated 03/18/2026, revealed the resident was a Yellow Assist level for meals. During an observation on 03/18/2026 at 11:28 AM, Certified Nursing Assistant (CNA) #2 entered Resident #70's room with a lunch tray, positioned the resident, provided meal set-up, asked the resident if the resident needed anything else, then exited the room. During an interview on 03/18/2026 at 11:30 AM, CNA #2 stated she believed Resident #70 was considered a yellow assist level for eating. She stated that yellow assist indicated the CNA opened everything for the resident and then needed to come back later to check on the resident. During an observation on 03/18/2026 at 11:32 AM, Resident #70 was in bed, eating lunch, with no staff present in the resident's room. During an interview on 03/18/2026 at 11:53 AM, CNA #2 stated she followed the meal tray card to know the level of assistance a resident required. During an interview on 03/18/2026 at 11:47 AM, Registered Nurse (RN) #3 stated yellow assist level indicated the resident required meal set-up assistance and could feed themself. She stated red assist level for dining indicated the resident needed help to eat. RN #3 referred to Resident #70's orders and stated the resident was considered a red assist level. She stated that the nursing staff followed the tray cards. She confirmed Resident #70's tray card indicated the resident was a yellow assist level and not red as it should have been. During an interview on 03/18/2026 at 12:44 PM, the Registered Dietician (RD) stated Resident #70's meal tray card did not indicate the resident was red level assist. She stated that the resident changed from yellow level to red level assist on 05/08/2025. She stated the resident had been changed to red level assist for nutrition purposes to maximize meal intake. During an interview on 03/19/2026 at 9:19 AM, Occupational Therapist (OT) #4 stated Resident #70 was having a low appetite and needed physical assistance to eat. She stated the resident could use their left hand to hold a fork but needed intermittent stand-by assistance. She stated that based on the order, the resident should have had assistance with eating since 05/08/2025. During an interview on 03/19/2026 at 10:41 AM, the Director of Nursing (DON) stated that the CNAs used the meal tray cards to identify the level of assistance a resident needed for eating. She stated Resident #70's diet order revealed the resident was considered a red assist level, and the meal tray card should have matched the order. She stated she expected the meal tray card to match the order. She stated her expectation for red assist was that the tray was taken into a resident's room when the staff was ready to assist the resident with the meal, and she expected the staff to stay with and assist the resident with their meal. During an interview on 03/19/2026 at 11:01 AM, the Administrator stated red assist level was when a CNA took a tray to a resident's room and assisted with the entirety of the dining process. He stated that the level of assistance for a resident was communicated to the CNAs on the meal tray ticket. He stated his expectation was that the tray card matched the diet order for the level of assistance a resident required.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on facility policy review, record review, and interview, the facility failed to ensure physician orders were obtained, as well as entered in the medical record for 1 (Resident #101) of 2 residents reviewed for the use of assistive devices. Specifically, the facility failed to obtain an order for a hip brace when the facility readmitted the resident with a hip brace and failed to transcribe an order to wear the hip brace over the resident's clothes. Findings included: A facility policy titled, Section VIII: Nursing Services Documentation Guidelines, revised 05/2025, revealed, General policies for orders: All orders should be directly entered into the EHR [electronic health record] upon receipt, or if handwritten by a provider, should be entered into the EHR from the written orders. All written orders will be scanned into the EHR. A Resident Face Sheet indicated the facility admitted Resident #101 on 05/16/2023 and re-admitted the resident on 05/27/2023. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of left hip hemiarthroplasty (a partial hip replacement) and left hip arthroplasty dislocation (dislocation of the hip after a hip replacement). Per the Resident Face Sheet, the facility discharged the resident on 07/12/2023. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/03/2023, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. Resident #101's Hospitalist Discharge Summary, dated 05/29/2023, indicated that the resident had a left hip dislocation due and had recently had a partial hip replacement. Per the record, the orthopedic provider included instructions to Mobilize in brace. Resident #101's Resident Orders revealed no physician order for the use of a brace on the resident's left hip. A handwritten physician order form from Resident #101's orthopedic surgeon, dated 06/15/2023, included orders to put their hip brace on over the resident's clothes. Resident #101's Resident Orders revealed no evidence of the orthopedic surgeon's order being transcribed as an order. Resident #101's June 2023 Medication Administration Record [MAR] revealed no evidence the orthopedic surgeon's order dated 06/15/2023 was transcribed on the MAR. During an interview on 03/18/2026 at 2:12 PM, the Assistant Director of Nursing (ADON) reviewed Resident #101's medical record and stated that she did not see an order for the hip brace. The ADON stated that the physician order from 06/15/2023 for the brace to be placed over the resident's clothes should have been entered into the EHR as an order. The ADON stated she did not know why the order was not put in the EHR, but it was important for the nurses to know to put the brace on over the resident's clothes. During an interview on 03/19/2026 at approximately 11:55 AM, the Director of Rehabilitation stated if an assistive device was present at the time of admission, the nurse notified therapy staff. She stated that if there was a clear order for the device, the nurse entered the order into the EMR, but if there was not, the therapist called the physician to get clarification. During an interview on 03/19/2026 at 12:39 PM, the Director of Nursing (DON) stated there was not an initial order for the hip brace for Resident #101. The DON stated that ideally, staff should have called the physician and clarified an order for the hip brace and transcribed the order. She stated that the physician order for the brace to go over the clothes should have been entered into the electronic health record after the doctor's appointment on 06/15/2023. During an interview on 03/19/2026 at 12:07 PM, the Administrator stated that when an outside provider sent an order, he expected nursing staff to receive the order and place it in the facility's provider's box. He stated that the facility's provider then approved the order, then the nurse entered the order into the electronic health record. The Administrator stated that he did not remember Resident #101.