STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445535	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurelbrook Nursing Home	200 Sanitarium Circle Dayton, TN 37321

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on interview, record review, and facility document and policy review, the facility failed to report allegations of resident-to-resident abuse and results of the investigations within the required timeframes for 3 allegations that involved 5 residents (Residents #2, #41, #23, #53, and #54) of 5 residents reviewed for abuse. A facility policy titled, Abuse, Neglect and Exploitation, revised 12/29/2025, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy also indicated, VII. A. 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. [exempli gratia, for example], law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury. 1. Resident #2's admission Record indicated the facility admitted the resident on ^08/01/2022^. According to the admission Record, the resident had a medical history that included diagnoses of nontraumatic intracerebral hemorrhage, anxiety disorder, schizoaffective disorder, and bipolar disorder. Resident #41's admission Record indicated the facility admitted the resident on ^07/03/2024^. According to the admission Record, the resident had a medical history that included diagnoses of cerebral infarction, anxiety disorder, and aphasia following cerebral infarction. A facility initial report to the state agency dated 03/14/2025 revealed that at 12:30 PM on 03/14/2025, Licensed Practical Nurse (LPN) #7 witnessed a physical and verbal altercation between Resident #41 and Resident #2. The report revealed the residents were seated in the facility foyer, separated by a bedside table. Per the report, Resident #2 did not like that Resident #41 was so close, and Resident #2 cursed Resident #41, then both residents stood up. Using the palms of their hands, Resident #41 pushed Resident #2 on their chest, and Resident #2 fell backward onto a bench. Resident #41, who was unsteady on their feet, stumbled and fell on the floor. Per the report, neither resident was injured during the incident, and the residents' responsible parties, the Administrator, Director of Nursing (DON), physician, and ombudsman were notified of the incident. The initial report revealed the facility submitted the physical and verbal abuse allegation to the state agency at 3:46 PM on 03/14/2025, three hours and sixteen minutes after the alleged resident-to-resident abuse. There was no documented evidence that the facility submitted a five-day follow-up report to the state agency. During an interview on 05/06/2026 at 2:32 PM, the DON stated an allegation of abuse should be reported to the state agency within two hours, but he was not always able to report within that timeframe. The DON further stated that a five-day follow-up report was not submitted to the state agency because they were waiting for a response regarding the initial report and never heard back from the state agency. During an interview on 05/05/2026 at 8:01 AM, the Administrator stated a five-day follow-up report was not submitted to the state agency following the resident-to-resident abuse allegation between Resident #2 and Resident #41 on 03/14/2025 because he had trouble uploading the report in the days following their investigation. During a follow-up interview on (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	05/07/2026 at 8:21 AM, the Administrator stated he expected allegations of abuse to be reported to the state agency within two hours if there was harm but believed if there was no harm, the facility had 24 hours to report an allegation of abuse. The Administrator further stated that the resident-to-resident abuse allegation between Resident #2 and Resident #41 was not reported within two hours because there was no harm to either resident. 2. An admission Record revealed Resident #23 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of degeneration of nervous system due to alcohol, unspecified dementia, alcohol dependence, major depressive disorder, and anxiety disorder. An admission Record revealed Resident #53 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. An initial report dated 11/06/2024 indicated, [Resident #23] was standing in the doorway to [Resident #53's] room when [Resident #53] came across [their] room and hit [Resident #23] in the face. The report revealed the incident occurred on 11/06/2024 at 8:15 AM. The report revealed the facility was aware of the incident on 11/06/2024 at 8:15 AM, but it was not reported to the state until 11/06/2024 at 11:15 PM, approximately 15 hours later. A five-day report dated 11/20/2024 indicated, As Activity staff came down the hall [Resident #23] was noted to be standing in the doorway of [Resident #53's room]. [Resident #53] started yelling at [Resident #23] telling [them] to get out of [their] room. [Resident #53] lunged at [Resident #23] and punched [them] in the face. [Resident #23] lost [their] balance and fell back into the closet door. Activity staff told [Resident #53] that [they] cannot hit other residents. [Resident #23] was removed from the area and Team 2 [the Assistant Director of Nursing] nurse notified of the incident. She requested [Resident #53] be on 1:1 supervision. Further review revealed that the report was submitted on 11/20/2024 at an unspecified time, approximately 14 days after the incident. During an interview on 05/06/2026 at 2:32 PM, the Director of Nursing (DON) stated the facility had a two-hour window to report allegations of abuse to the state agency. He stated that the initial report for the incident between Resident #23 and Resident #53 was delayed because that was the time it took to get everything processed, and the facility had exceeded the two-hour timeframe. During an interview on 05/07/2026 at 8:20 AM, the Administrator stated he and the DON were the Abuse Coordinators at the facility. The Administrator stated the facility reported abuse according to the regulations; if there was harm, they reported immediately or within two hours and if there was no harm, then they reported it within 24 hours. The Administrator stated that regarding the incident between Resident #23 and Resident #53, that initial report was delayed because he believed the facility had 24 hours to make the report. The Administrator stated he was not sure why the five-day report for that incident was not submitted until 11/20/2024. 3. An admission Record revealed Resident #54 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, depression, generalized anxiety disorder, weakness, and bed confinement status. An admission Record revealed Resident #53 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. An initial report dated 11/20/2024 indicated that Resident #54 accused Resident #53 of threatening to choke them. The report revealed the incident occurred on 11/19/2024 at 9:30 PM. The report revealed the facility was made aware of the allegation on 11/20/2024 at 8:45 AM, but it was not reported to the state until 11/20/2024 at 6:16 PM, approximately nine hours later. The facility was unable to provide the five-day Report for the incident between Resident #54 and Resident #53. During an interview on 05/05/2026 at 8:03 AM, the Administrator stated there was no 5-day report for the incident between Resident #54 and Resident #53. During an interview on 05/06/2026 at 2:32 PM, the Director of Nursing (DON) stated the facility had a two-hour window to report allegations of abuse to the state agency. He stated that the initial report for the incident between Resident #53 and Resident #54 was delayed because by the time they (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed the report, the facility had exceeded the two-hour timeframe. He stated he did not know why there was no 5-day report for the incident between Resident #53 and Resident #54. During an interview on 05/07/2026 at 8:20 AM, the Administrator stated he and the DON were the abuse coordinators at the facility. The Administrator stated the facility reported abuse according to the regulations; if there was harm, they reported immediately or within two hours and if there was no harm, then they reported it within 24 hours. The Administrator stated that regarding the incident between Resident #53 and Resident #54, the initial report was delayed because he believed the facility had 24 hours to make that report.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document and policy review, the facility failed to conduct thorough abuse investigations for threeˆallegations that involvedˆ5 (Residentsˆ#2, #41,ˆ#23,ˆ#53, andˆ#54) of 5 residents reviewed forˆabuse.ˆˆ Findings included: A facility policy titled, Abuse, Neglect and Exploitation, revised 12/29/2025, indicated, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. The policy also indicated, A. An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse, neglect or exploitation occur. B. Written procedures for investigations include: 1. Identifying staff responsible for the investigation; 2. Exercising caution in handling evidence that could be used in a criminal investigation (e.g. [exempli gratia, for example], not tampering or destroying evidence); 3. Investigating different types of alleged violations; 4. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, 5. Focusing the investigation on determining if abuse, neglect, exploitation, and / or mistreatment has occurred, the extent, and cause; and 6. Providing complete and thorough documentation of the investigation. 1. Resident #2's admission Record indicated the facility admitted the resident on ˆ08/01/2022ˆ. According to the admission Record, the resident had a medical history that included diagnoses of nontraumatic intracerebral hemorrhage, anxiety disorder, schizoaffective disorder, and bipolar disorder. Resident #41's admission Record indicated the facility admitted the resident on ˆ07/03/2024ˆ. According to the admission Record, the resident had a medical history that included diagnoses of cerebral infarction, anxiety disorder, and aphasia following cerebral infarction. The facility's initial report to the state agency dated 03/14/2025 indicated that at 12:30 PM, Licensed Practical Nurse (LPN) #7 witnessed a physical and verbal altercation between Resident #41 and Resident #2 after being in proximity to each other in the foyer of the nursing home. Per the report, Resident #2 did not like that Resident #41 was in their personal space, so Resident #2 cursed at Resident #41, then both residents stood up in an aggressive stance. The report revealed that using the palm of their hands, Resident #41 pushed Resident #2 on their chest, who then fell backward onto the couch. Pre the report, neither resident was injured during the incident, and the facility notified both residents' responsible parties, the Administrator, Director of Nursing (DON), physician, and ombudsman. The report revealed that nursing staff immediately assessed both residents, with no injuries noted. The report revealed Resident #2 and Resident #41 were immediately separated and placed on 1:1 observation for four hours then every 15-minute checks thereafter for 24 hours. Per the report, both residents had a psychiatric consultation, had medication adjustments, and were found to not present a danger to any other residents. The report revealed both residents de-escalated within a few minutes and apologized to each other. Further review revealed there was no evidence that a threat continued to exist. The facility's investigation did not include interviews or assessments of other cognitive and non-cognitive residents. During an interview on 05/05/2026 at 4:07 PM, LPN #7 stated witness statements from staff in the vicinity were taken, but she was not sure how other residents were assessed for potential abuse following the altercation. During an interview on 05/06/2026 at 2:32 PM, the DON stated a thorough investigation following an allegation of abuse included a resident's comprehensive chart review and staff and resident interviews related to the allegation. The DON further stated there was no indication there was potential abuse with other verbal and non-verbal residents, so they did not assess anyone else other than Resident #2 and Resident #41 for potential signs of abuse. During an interview on 05/07/2026 at 8:21 AM, the Administrator stated a thorough investigation included witness statements and provider follow-up for ongoing clinical concerns. The Administrator stated that for this incident other residents were not interviewed related to potential abuse because it appeared to be an isolated incident. 2. An admission Record revealed (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #23 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of degeneration of nervous system due to alcohol, unspecified dementia, alcohol dependence, major depressive disorder, and anxiety disorder. An admission Record revealed Resident #53 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. An initial report submitted to the state agency on 11/06/2024 at 11:15 PM, indicated Resident #23 was standing in the doorway to Resident #53's room when Resident #53 came across their room and hit Resident #23 in the face. The report revealed witnesses included the Former Activities Director. A five-day report submitted to the state agency on 11/20/2024, indicated, As Activity staff came down the hall [Resident #23] was noted to be standing in the doorway of [Resident #53's room]. [Resident #53] started yelling at [Resident #23] telling [them] to get out of [their] room. [Resident #53] lunged at [Resident #23] and punched [them] in the face. [Resident #23] lost [their] balance and fell back into the closet door. Activity staff told [Resident #53] that [they] cannot hit other residents. [Resident #23] was removed from the area and Team 2 [the Assistant Director of Nursing] nurse notified of the incident. She requested [Resident #53] be on 1:1 supervision. During an interview on 05/06/2026 at 1:46 PM, the Administrator stated they had provided everything they had on the investigation for the incident between Resident #23 and Resident #53. He stated they completed witness statements and other components of the investigation but were unable to find them. During an interview on 05/06/2026 at 2:32 PM, the Director of Nursing (DON) stated a thorough abuse investigation included interviewing the involved residents, interviewing the involved staff, pulling the medical records for each resident involved, and filling out a concern form. He stated that he did not know where the signed witness statements or body audits were for the incident between Resident #23 and Resident #53. During an interview on 05/07/2026 at 8:20 AM, the Administrator stated a thorough investigation included interviews with witnesses, the perpetrator, and victims. The Administrator stated that to give their statement, they filled out a statement form and if they were unable to write, the interviewer could write it for them. The Administrator stated that regarding the incident between Resident #23 and Resident #53, they talked to people but somehow the statements did not make it into the investigation files. 3. An admission Record revealed Resident #54 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, depression, generalized anxiety disorder, weakness, and bed confinement status. An admission Record revealed Resident #53 was admitted to the facility on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of bipolar disorder, major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder. An initial report dated 11/20/2024 indicated Resident #54 accused Resident #53 of threatening to choke them. The report revealed the incident occurred on 11/19/2024 at 9:30 PM. The facility was unable to provide the five-day Report for the incident between Resident #54 and Resident #53. During an interview on 05/06/2026 at 1:46 PM, the Administrator stated they had provided everything they had on the investigation for the incident between Resident #54 and Resident #53. He stated they completed witness statements and other components of the investigation but were unable to find them. During an interview on 05/06/2026 at 2:32 PM, the Director of Nursing (DON) stated a thorough abuse investigation included interviewing the involved residents, interviewing the involved staff, pulling the medical records for each resident involved, and filling out a concern form. He stated that he did not know why they could not find the investigation for the incident between Resident #54 and Resident #53. During an interview on 05/07/2026 at 8:20 AM, the Administrator stated a thorough investigation included interviews with witnesses, the perpetrator, and victims. The Administrator stated that to give their statement, they filled out a statement form and if they were unable to write, the interviewer could write for them. The Administrator stated that regarding the incident between Resident #53 and Resident #54, he stated they talked to people but somehow the statements did not make it into the investigation files

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, facility policy review, and Centers for Medicare and Medicaid Services (CMS) guidelines, the facility failed to ensure staff implemented enhanced barrier precautions (EBP) for 1 (Resident #29) 2 sampled residents reviewed for infection control. Findings included: A facility policy titled, Enhanced Barrier Precautions, revised 10/01/2025, indicated, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy specified in the section Initiation of Enhanced Barrier Precautions that, b. A standing order for enhanced barrier precautions will be used for residents with any of the following: i. Wounds (e.g. [exempli gratia, for example], chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous status ulcers) and/or indwelling medical devices (e.g., urinary catheters, feeding tubes, tracheostomy, hemodialysis catheters, [sic]) even if the resident is not known to be infected or colonized with a MDRO [multidrug-resistant organism]. The policy specified in the section, Implementation of Enhanced Barrier Precautions that, a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray. The policy also indicated, PPE [Proper Protective Equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. The policy also indicated, 4. High-contact resident care activities include, and g. Device care or use: urinary catheters, feeding tubes, tracheostomy, hemodialysis catheter. A Centers for Medicare and Medicaid Services memorandum, QSO-24-08-NH, titled, Enhanced Barrier Precautions in Nursing Homes, dated 03/20/2024 and effective 04/01/2024, in the section, Memorandum Summary, revealed, EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. Under the section, Guidance, the memorandum revealed, Indwelling medical device examples include central lines, urinary catheters, feeding tubes, and tracheostomies. An admission Record revealed the facility admitted Resident #29 on 10/05/2006. According to the admission Record, the resident had a medical history that included diagnoses of gastrostomy status, bed confinement status, and gastro-esophageal reflux disease with esophagitis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/21/2026, revealed Resident #29 had a feeding tube while a resident. Resident #29's Care Plan Report, included a focus area initiated 07/20/2020, that indicated the resident had a PEG (Percutaneous Endoscopic Gastrostomy tube, a tube placed from the abdominal wall into the stomach) tube feeding. Interventions directed staff to provide local care to the tube site as ordered and to monitor the site for signs and symptoms of infection (07/20/2020). Resident #29's Care Plan Report did not include EBP. Resident #29's Order Summary Report, with active orders as of 05/04/2026, revealed, NPO [nil per os, nothing by mouth] diet, NPO texture, NPO consistency, Tube feeding, dated 02/21/2024. The Order Summary Report did not include EBP. Resident #29's Certified Nursing Assistant's (CNA) task list (a list describing essential patient care tasks) did not include EBP. An observation, on 05/04/2026 at 9:49 AM, revealed that Registered Nurse (RN) #3 administered medication to Resident #29 via the PEG tube while wearing gloves, but RN #3 did not wear a gown. RN #3 stated they wore gloves when providing a tube feeding, and RN #3 did not provide an explanation for not wearing a gown. The observation revealed no EBP posting for Resident #29's room. On 05/04/2026 at 10:00 AM, CNA #4 stated she did not wear a gown during incontinence care, dressing, or linen changes for Resident #29. ^^ On 05/04/2026 at 3:40 PM, the Director of Nursing (DON) stated RN #3 broke infection control protocol by failing to wear a gown during care provided to Resident #29. On 05/05/2026 at 9:57 AM, the Infection Preventionist (IP) stated she was unaware that Resident #29's room lacked the required signage. The IP confirmed that RN #3 should have worn a gown during medication administration via the PEG tube to prevent the spread of organisms. The IP stated that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gowns were required during close-contact care including linen changes, dressing, and incontinence care, and CNA #9 did not follow proper EBP precautions. ˆ On 05/05/2026 at 10:12 AM, the Minimum Data Set Coordinator (MDSC) stated that EBP must be documented on the CNA's task list to ensure staff were aware of and followed the required precautions. The MDSC stated Resident #29 did not have an order for EBP. The MDSC stated she had not been adding the EBP to the CNA's task list because she was just made aware of the need the day prior. The MDSC stated she was also responsible to ensure Resident #29 had an order for EBP. On 05/06/2026 at 1:03 PM, the Director of Nursing (DON) stated they expected RN #3 to follow EBP, including wearing gloves and a gown, for Resident #29. The DON stated they expected the same precautions to be followed by CNA #4, including the use of gloves and a gown. ˆ On 05/07/2026 at 8:09 AM, the Administrator (ADM) stated the expectation was for facility staff to wear proper PPE during medication administration to Resident #29. The ADM stated CNA #4 was also expected to wear appropriate PPE.