STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER: Advanced Health Care of Nashville		STREET ADDRESS, CITY, STATE, ZIP CODE: 627 19th Ave North Nashville, TN 37203	

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to protect the resident's right to be free from neglect by facility staff for 1of 4 (Resident #1) sampled residents reviewed for abuse. On 8/18/2024, LPN G witnessed Resident #1's private sitter restraining his arms across his abdomen after an attempt to obtain a blood sample while the resident yelled No. Licensed Practical Nurse (LPN) G witnessed the private sitter's behavior escalate to crying and yelling before she left Resident #1 and the private sitter alone in the room. LPN G failed to protect Resident #1 from further potential abuse when she left Resident #1 alone in the room with the private sitter after she obtained the blood sample, which resulted in Immediate Jeopardy (IJ) for Resident #1. An Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, Director of Nursing, and Regional [NAME] President were notified of the Immediate Jeopardy for F-600 on 10/2/2024 at 3:10 PM in the Administrator's office. The facility was cited at F-600 at a scope and severity of J, which constitutes Substandard Quality of Care. The Immediate Jeopardy was effective on 8/18/2024 and is on-going. A partial extended survey was conducted on 9/20/2024 to 10/2/2024. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility policy titled, ABUSE POLICY AND PROCEDURE, updated 7/25/2023, revealed .Any form of resident/patient abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services will not be tolerated .It is the responsibility of all employees to report resident/patient abuse . Patients will not be subjected to abuse by anyone including staff, other patients, consultants, or volunteers, contract employees or staff from other agencies serving our patients, family members, or legal guardians, friends, or other individuals .All patients will be protected from any and all forms of abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services .PREVENTION . (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: 445538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Nashville		STREET ADDRESS, CITY, STATE, ZIP CODE 627 19th Ave North Nashville, TN 37203	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, USE OF RESTRAINTS, dated 9/28/2022, revealed .Each patient has the right to be free from physical restraints imposed for purposes of discipline or convenience . Review of the facility documentation of LPN G's employee record revealed she received an abuse in-service upon hire on 4/19/2024 and on 8/8/2024 at the monthly in-services. Review of the facility documentation of the private sitter's employee record, who was a previous employee, revealed abuse in-service upon hire. The private sitter was terminated on 7/26/2024. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis of vertebra and sacrococcygeal region. Further review revealed Resident #1 had diagnoses which included Major Depressive Disorder and Anxiety. Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE], for Resident #1 revealed a Brief Interview of Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. Review of the Comprehensive Care Plan for Resident #1 revealed, .8/5/2024 .Alteration in mood status: ANXIETY .8/15/2024 .Patient has identified history of TRAUMA .previous abusive situation at previous SNF and PTSD [Post Traumatic Stress Disorder] from this . Review of the facility investigation dated 8/20/2024, revealed the Director of Nursing (DON) became aware of the allegation of abuse on 8/20/2024 at 11:30 AM, when Family Member (FM) H reported it. FM H reported that on 8/18/2024 at approximately 7:00 PM, she was on the phone when Resident #1 attempted to stand up and the private sitter was trying to get him to sit down. Resident #1 became combative and started to hit the private sitter. FM H stated she heard the private sitter start yelling at him over the phone and believed that Resident #1 was restrained. FM H stated she called the private sitter to question her, and she became loud and belligerent stating she had the right to defend herself. FM H stated she called FM N to call the private sitter and speak with her. The private sitter yelled at FM N, too. FM H called the private sitter back and asked her to leave, but she refused. FM H called the front desk to have the private sitter removed. The private sitter finally left the facility. The DON notified the Administrator of the allegation of abuse, and she reported to the Ombudsman and the State Agency. The Administrator substantiated the abuse. During an interview on 9/5/2024 at 10:52 AM, Licensed Practical Nurse (LPN) G stated she worked the 100 Hall on the day (8/18/2024) of the alleged abuse. LPN G was told by the phlebotomist that she was unable to obtain blood due to Resident #1's increased agitation. LPN G stated shortly afterwards, she walked into Resident #1's room and observed the private sitter restraining Resident #1 by holding his arms across his body. LPN G stated she told the private sitter not to hold Resident #1's arms down because the law may not permit this. The private sitter responded Resident #1 had hit her. During an interview on 9/5/2024 at 11:55 AM, the Administrator stated she was notified of the allegation of abuse involving Resident #1 on Tuesday (8/20/2024) after FM H notified the DON. The Administrator stated she initiated an investigation and based on the findings, substantiated abuse. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445538	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Nashville	627 19th Ave North Nashville, TN 37203

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/5/2024 at 1:15 PM, the DON was asked when she was made aware of the allegation of abuse. The DON stated she was notified on 8/20/2024 the alleged abuse occurred during a meeting with Resident #1's wife, FM H. FM H told the DON she was on speaker phone and heard the private sitter yelling at Resident #1. FM H also stated to the DON that LPN G was in the room too. The DON contacted LPN G for an interview on 8/20/2024, after notification of the abuse. LPN G told the DON she walked into the room and observed the private sitter wrestling with Resident #1. The DON asked LPN G why she did not report what she observed immediately. LPN G stated she told the private sitter to stop what she was doing. Continued interview revealed the DON stated LPN G had been previously educated on abuse and had no excuse for not reporting immediately. Further interview revealed the expectation of the DON for all staff on any form of abuse was to make sure the resident was safe and report immediately to herself or the Administrator. During an interview on 9/5/2024 at 4:10 PM, Registered Nurse (RN) J stated he was the supervisor on 8/18/2024 and was not made aware of any allegation of abuse. During a telephone interview on 9/5/2024 at 4:28 PM, RN K stated she witnessed a telephone conversation on 9/4/2024 between the Clinical Nurse Manager and LPN G regarding the alleged abuse incident on 8/18/2024. LPN G had stated she walked into Resident #1's room and the private sitter was holding both wrists down beside his body. RN K stated LPN G said she did not think this was abuse and was more concerned about obtaining blood for labs. During a telephone interview on 9/9/2024 at 10:13 AM, FM H stated she was on the phone with Resident #1 when she heard the private sitter yelling in the background, which made Resident #1 more agitated. (Resident #1 had experienced a previous trauma from another facility.) FM H then stated she called the private sitter to try to speak with her, but she continued to yell and be belligerent. She stated FM N called the private sitter also, and she was belligerent to him as well. During a telephone interview on 9/9/2024 at 3:30 PM, FM N stated he heard the private sitter in the background when he called his father (Resident #1) to try to calm him down. FM N then called the private sitter, and she continued to yell, saying she was not going to be hit. Multiple attempts were made to contact the private sitter for interview with no success. During a telephone interview on 9/25/2024 at 2:35 PM, Senior [NAME] President (VP) of the (named) Lab was on the call with the phlebotomist. The phlebotomist was asked to recall the day of 8/18/2024 at the facility with Resident #1. The phlebotomist stated she entered the room and found Resident #1 to be alert but confused. She stated she told Resident #1 what she was about to do, and he said okay. The phlebotomist tried to calm Resident #1 down. She stated she held one arm, and the private sitter held the other. The phlebotomist stated the private sitter held the left arm of Resident #1 across his abdomen while she held the right arm between her knees to try to obtain a blood sample, because that was how she was trained to do if a patient was combative. Resident #1 became increasingly combative while refusing and yelling, No. The phlebotomist left the room and notified LPN G she could not obtain the blood sample. The private sitter remained in the room with Resident #1. When asked if she (the phlebotomist) was in the room when LPN G entered, the phlebotomist stated, No. During a telephone interview on 9/26/2024 at 4:47 PM, the phlebotomist was asked if a resident has the right to refuse treatment and she replied, Yes. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Advanced Health Care of Nashville		STREET ADDRESS, CITY, STATE, ZIP CODE: 627 19th Ave North Nashville, TN 37203	

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/30/2024 at 1:58 PM, LPN G was asked to recall the witnessed abuse incident with Resident #1 on the day of 8/18/2024. LPN G stated when she entered Resident #1's room, the private sitter had his arms held down across his chest. She stated she told the private sitter that she was unaware of the law in Tennessee, but she needed to let Resident #1 go. The private sitter let Resident go after she told LPN G that he had been combative and hit her. LPN G stated she called FM H to try to comfort Resident #1 before trying to obtain the blood sample. There was back and forth conversation going on via speaker phone with the private sitter, FM H, and FM N that led to the private sitter being asked to leave the facility by the family. LPN G stated after she obtained the blood sample, she exited the room leaving Resident #1 and the private sitter alone in the room. LPN G stated she stood in the hallway for a few minutes then went back up the hallway and gave report to the night nurse. Continued interview revealed LPN G did not report the witnessed abuse per the facility policy. During a telephone interview on 9/30/2024 at 4:32 PM, the phlebotomist confirmed the private sitter remained in Resident #1's room when LPN G went to draw blood. The phlebotomist was asked when LPN G left the room, did the private sitter remain with Resident #1. The phlebotomist stated, Yes. Once the blood was obtained, LPN G left the room while Resident #1 remained with the private sitter. During a telephone interview on 10/1/2024 at 10:23 AM, LPN Q, who was the night shift nurse on 8/18/2024, stated FM H called the facility to check on Resident #1 and said she had fired the private sitter. LPN Q was headed to Resident #1's room when she saw the private sitter leaving the facility. When asked the date and time of this call, LPN Q stated she did not remember the date but did recall the time to be approximately 8:00 PM. During an interview on 10/2/2024, the DON stated when she interviewed LPN G, the LPN eventually admitted she witnessed the private sitter holding down Resident #1's arms across his abdomen. LPN G was asked by the DON if she removed the private sitter from the room and LPN G said No, the private sitter was belligerent at that time. When the DON asked LPN G why she did not report the incident, the LPN stated she took care of it and asked her to let go of Resident #1.

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to provide an environment free from the use of physical restraint used for staff convenience, that unnecessarily inhibited a resident's freedom of movement or activity for 1 of 1 (Resident #1) sampled residents reviewed for restraints. On 8/18/2024, a phlebotomist from an outside agency contracted with the facility and Resident #1's private sitter physically restrained Resident #1, while he yelled No during an attempt to obtain blood. The phlebotomist notified Licensed Practical Nurse (LPN) G that she was unable to obtain the blood, and LPN G entered Resident #1's room and observed Resident #1's private sitter holding his arms down across his body. The facility's failure to ensure an environment free from physical restraints for Resident #1 resulted in an Immediate Jeopardy (IJ). An Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, Director of Nursing, Regional [NAME] President, and Regional Nurse were notified of the Immediate Jeopardy for F-604 on 10/2/2024 at 3:15 PM in the Administrator's office. The facility was cited at F-604 at a scope and severity of J, which constitutes Substandard Quality of Care. The Immediate Jeopardy was effective on 8/18/2024 and is on-going. A partial extended survey was conducted on 9/20/2024 to 10/2/2024. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility policy titled, ABUSE POLICY AND PROCEDURE, updated 7/25/2023, revealed .Any form of resident/patient abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services will not be tolerated .It is the responsibility of all employees to report resident/patient abuse . Patients will not be subjected to abuse by anyone including staff, other patients, consultants, or volunteers, contract employees or staff from other agencies serving our patients, family members, or legal guardians, friends, or other individuals .All patients will be protected from any and all forms of abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services .PREVENTION .The Administrator or designee will request verification from the contracting agency or entity of the contract employee/agency personnel's compliance with required background screening and license/certification verification .The Administrator or designee will ensure the contract employee or agency personnel is without and [an] unemployable criminal history and licensure/certification is in good standing .REPORTING AND INVESTIGATING .The person(s) observing the incident of patient abuse or suspecting patient abuse must immediately ensure patient safety then immediately report such incidents to their immediate supervisor and/or the charge nurse .The Administrator or Director of Nursing will then ensure the safety of the patient, begin the investigation, and if necessary, report information to the police . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Advanced Health Care of Nashville	627 19th Ave North Nashville, TN 37203

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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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility policy titled, USE OF RESTRAINTS, dated 9/28/2022, revealed .Each patient has the right to be free from physical restraints imposed for purposes of discipline or convenience . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis of vertebra and sacrococcygeal region, Parkinson's disease without dyskinesia (uncontrolled, involuntary muscle movement), Anxiety, and Major Depressive Disorder. Review of the 5-Day Minimum Data Set (MDS) assessment for Resident #1 dated 8/19/2024, revealed a Brief Interview of Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment. Review of Comprehensive Care Plan for Resident #1 revealed, .8/5/2024 .Alteration in mood status: ANXIETY .8/15/2024 Patient has identified history of TRAUMA .previous abusive situation at previous SNF [Skilled Nursing Facility] and PTSD [Post Traumatic Stress Disorder] from this . Review of the Facility Reported Investigation dated 8/20/2024, revealed the Director of Nursing (DON) was made aware of the allegation of abuse on 8/20/2024 at 11:30 AM, when Family Member (FM) H reported it. FM H reported, .On 8/18/2024, she was on the speaker phone when Resident #1 .[named Resident #1] attempted to stand up .the private sitter was trying to get him to sit down .[named Resident #1] started to become combative and hit the private sitter .I [FM H] heard the private sitter yelling at him over the phone .I called the private sitter to question her and she became 'loud and belligerent' .she said she had the right to defend herself .FM H stated she called FM N to call CNA F and speak with [named private sitter] .the private sitter yelled at FM N too . FM H made an attempt to speak with the private sitter and had no success due to her yelling. FM H stated, 'I called the private sitter back and asked her to leave' .the private sitter refused .FM H called the front desk to have the private sitter removed .the DON notified the Administrator of the allegation of abuse and she reported to the State Agency .The findings of the Administrator substantiated the abuse . During an interview on 9/5/2024 at 10:52 AM, Licensed Practical Nurse (LPN) G stated, .I worked 100 Hall on the day (8/18/2024) of the alleged abuse .the phlebotomist came and reported to me that she was unable to obtain blood due to [named Resident #1]'s increased agitation .I walked into [named Resident #1]'s room and observed the private sitter restraining Resident #1 by holding his arms across his body .I told her [private sitter] not to hold Resident #1's arms down .the [named private sitter] said Resident #1 had hit her. During an interview on 9/5/2024 at 11:55 AM, the Administrator stated she was notified of the allegation of abuse involving Resident #1 on Tuesday (8/20/2024) after FM H notified the DON. The Administrator stated she initiated an investigation and based on the findings, substantiated abuse. The private sitter was reported to the abuse registry. (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 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 9/5/2024 at 1:15 PM, the DON was asked when she was made aware of the allegation of abuse. The DON stated she was notified the day after (8/20/2024) the alleged abuse occurred during a meeting with Resident #1's wife, FM H. FM H told the DON she was on speaker phone and heard the private sitter yelling at Resident #1. FM H also stated to the DON that LPN G was in the room too. The DON contacted LPN G for an interview on 8/20/2024 after notification of the abuse. LPN G told the DON she walked into the room and observed the private sitter wrestling with Resident #1 and holding his arms down. The DON asked LPN G why she did not report what she observed immediately. LPN G stated she told the private sitter to stop what she was doing. Continued interview revealed the DON stated LPN G had been previously educated on abuse and had no excuse for not reporting immediately what she had observed. Further interview revealed the expectation of the DON for all staff on any form of abuse was to make sure the resident was safe and report immediately to herself or the Administrator. During a telephone interview on 9/5/2024 at 4:28 PM, RN K stated she witnessed a telephone conversation on 9/4/2024 between the Clinical Nurse Manager and LPN G regarding the alleged abuse. RN K stated LPN G stated she walked into Resident #1's room and the private sitter was holding both wrists down beside his body. RN K asked LPN G why she did not report this immediately. LPN G stated she did not think this was abuse and was more concerned about obtaining blood for labs. During a telephone interview on 9/9/2024 at 10:13 AM, FM H stated she was on the phone when she heard the private sitter yelling in the background, which made Resident #1 more agitated. (Resident #1 had experienced a previous trauma from another facility.) FM H then stated she called the private sitter to try to speak with her, but she continued to yell and be belligerent. FM H told the private sitter not to hold down Resident #1's arms. FM H stated FM N called the private sitter also and she was belligerent to him as well. LPN G was asked if she reported the incident to anyone at the facility and she responded she thought (LPN G) would have reported the incident since she was in the room at the time. During a telephone interview on 9/9/2024 at 3:30 PM, FM N stated he heard the private sitter yelling in the background when he called his father (Resident #1) to try to calm him down. FM N then called the private sitter, and she continued to yell, saying she was not going to be hit. The surveyor attempted to contact Resident #1's private sitter multiple times with no success. During a telephone interview on 9/25/2024 at 2:35 PM, Senior [NAME] President for (named) Lab orchestrated a call between the surveyor and phlebotomist who worked on 8/18/2024. The phlebotomist stated she entered Resident #1's room and observed someone with the patient, .a middle-aged black lady with glasses and short, curly hair who was identified as Resident #1's private sitter . She stated she informed Resident #1, who was alert but confused, that she needed to obtain some blood. The phlebotomist stated she tried to calm Resident #1 down, but he became extra combative. The phlebotomist stated she had one arm, and the private sitter had the other arm. When asked to explain what she meant by having his arms, the phlebotomist stated she put Resident #1's right arm between her legs and the private sitter held his left arm down across his abdomen, but not with force. The phlebotomist stated Resident #1 hit her and became more combative even after she and the private sitter held his arms to try to obtain blood. She stated she was not going to fight with Resident #1 anymore and reported his behavior to LPN G. When asked if Resident #1 refused at any time, the phlebotomist stated, He [Resident #1] was saying no the whole time I was trying to get blood. Continued interview revealed when the phlebotomist left the room, the private sitter remained with Resident #1. (continued on next page)

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F 0604 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a telephone interview on 9/26/2024 at 4:47 PM, the phlebotomist was asked if a resident did not want treatment, did they have the right to refuse treatment. The phlebotomist responded, Yes. During a telephone interview on 9/30/2024 at 1:58 PM, LPN G was asked what she observed when she entered Resident #1's room. LPN G stated she observed the private sitter holding down Resident #1's arms across his abdomen and chest. She stated she told the private sitter she was unaware of the laws in Tennessee but to release the resident. The private sitter stated Resident #1 was combative and hit her but did release his arms. LPN G was then asked if she left the private sitter alone in the room with Resident #1 after she obtained the blood sample. LPN G stated she did leave the room and left Resident #1 alone with the private sitter. She stated she stayed outside the door for a few minutes and then went up the hallway to give report to the LPN Q. LPN G failed to protect Resident #1 from the likelihood of further abuse after she observed Resident #1's private sitter physically restrain him and then left Resident #1 alone with the private sitter. LPN G failed to protect Resident #1 and failed to report the incident immediately.

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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 - Immediate jeopardy to resident health or safety 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** 46831 Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to report an allegation of abuse for 1 of 4 (Resident #1) sampled residents reviewed for abuse. On 8/18/2024, Resident #1, a moderately, cognitively impaired resident was physically restrained by his private sitter while refusing a venipuncture (a procedure in which a needle is used to take blood from a vein). Licensed Practical Nurse (LPN) G observed the private sitter continuing the physical restraint of Resident #1 after the venipuncture attempt. LPN G failed to report the allegation of abuse to Administration. The facility's failure to ensure all allegations of abuse were reported immediately resulted in an Immediate Jeopardy (IJ). An Immediate Jeopardy is a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. The Administrator, Director of Nursing, and Regional [NAME] President were notified of the Immediate Jeopardy for F-609 on 10/2/2024 at 3:10 PM in the Administrator's office. The facility was cited at F-609 at a scope and severity of J, which constitutes Substandard Quality of Care. The Immediate Jeopardy was effective on 8/18/2024 and is on-going. A partial extended survey was conducted on 9/20/2024 to 10/2/2024. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility policy titled, ABUSE POLICY AND PROCEDURE, updated 7/25/2023, revealed .Any form of resident/patient abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services will not be tolerated .It is the responsibility of all employees to report resident/patient abuse . REPORTING AND INVESTIGATING .The person(s) observing the incident of patient abuse or suspecting patient abuse must immediately ensure patient safety then immediately report such incidents to their immediate supervisor and/or the charge nurse .The Administrator or Director of Nursing will then ensure the safety of the patient, begin the investigation, and if necessary, report information to the police . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis of vertebra and sacrococcygeal region. Further review revealed Resident #1 had diagnoses which included Major Depressive Disorder and Anxiety. Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Review of the Comprehensive Care Plan for Resident #1 revealed, .8/5/2024 .Alteration in mood status: ANXIETY .8/15/2024 .Patient has identified history of TRAUMA .previous abusive situation at previous SNF [Skilled Nursing Facility] and PTSD [Post Traumatic Stress Disorder] from this . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445538	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/02/2024
NAME OF PROVIDER OR SUPPLIER Advanced Health Care of Nashville		STREET ADDRESS, CITY, STATE, ZIP CODE 627 19th Ave North Nashville, TN 37203	

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility investigation dated 8/20/2024, revealed the Director of Nursing (DON) became aware of the allegation of abuse on 8/20/2024 at 11:30 AM, when family member (FM) H reported it. FM H reported on 8/18/2024 at approximately 7:00 PM, she was on the phone when Resident #1 attempted to stand up and the private sitter tried to make him sit down. Resident #1 became combative and started to hit the private sitter. FM H stated she heard the private sitter start yelling at him over the phone and believed he was restrained. FM H stated she called the private sitter to question her, and the private sitter became loud and belligerent stating she had the right to defend herself. FM H stated she called FM N to call the private sitter and speak with her. The private sitter yelled at FM F, also. FM H call the private sitter back and asked her to leave. The private sitter refused. FM H called the front desk to have the private sitter removed. The DON notified the Administrator of the allegation of abuse, and she reported to the Ombudsman and the State Agency. No physical injury was found. The Administrator substantiated the abuse. During an interview on 9/5/2024 at 10:52 AM, LPN G stated on 8/18/2024, the phlebotomist reported an unsuccessful attempt to obtain a blood specimen due to Resident #1's refusal to cooperate with the procedure. LPN G stated upon entering Resident #1's room, she observed the private sitter restraining Resident #1's arms across his body. LPN G stated Resident #1 was experiencing increased agitation, refusing care, and she directed the private sitter to stop holding the resident down. Continued interview revealed LPN G stated the private sitter then replied, .He hit me . Continued interview revealed LPN G was asked if she reported the alleged abuse and she stated she did not. During an interview on 9/5/2024 at 11:55 AM, the Administrator stated she was notified of the allegation of abuse on 8/20/2024. The Administrator affirmed LPN G should have reported the allegation of abuse immediately. Continued interview revealed the Administrator acknowledged the facility is required to report allegations of abuse within 2 hours of the allegation to the state agency. During an interview on 9/5/2024 at 1:15 PM, the DON was asked when she was made aware of the allegation of abuse. The DON stated she was notified of the allegation of abuse on 8/20/2024 during a meeting by FM H. During a telephone interview on 9/9/2024 at 10:13 AM, FM H stated, .That Sunday [8/18/2024] [named LPN G] called me because [named Resident #1] was refusing to allow blood to be drawn .I was on speaker phone with [named Resident #1] trying to calm him down, when I heard [named private sitter] yelling and being belligerent .[named private sitter] was screaming, 'He [Resident #1] tried to hit me so I held him .I know what I'm doing' . FM H stated the private sitter's behavior increased Resident #1's anxiety. FM H stated, .I tried to explain to [Named private sitter] that she needed to calm down .I told her not to hold [Named Resident #1] down .she [private sitter] kept yelling that she had a right to defend herself .I asked her [private sitter] to leave, and she refused to leave . When asked if she reported the incident to the facility, FM H responded, .I assumed, because [named LPN G] called me and was present in the room, that she would pass it on . During a telephone interview on 9/9/2024 at 3:30 PM, FM N stated (named FM H) called him (8/18/2024) because the private sitter would not leave the facility. FM N stated that he called and attempted to talk with the private sitter, and she continued to yell, .I am not going to be hit . FM N stated the private sitter refused to continue talking and hung up the phone. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility's failure to ensure timely reporting of the allegation of abuse/physical restraint of Resident #1, increased the likelihood that additional abuse could occur and compromise or impede the protection of all residents residing in the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46831 Based on facility policy review, medical record review, and interview, the facility failed to conduct a thorough investigation and take appropriate corrective actions for 1 of 1 (Resident #1) sampled residents reviewed for abuse. The findings included: Review of the facility policy titled, ABUSE POLICY AND PROCEDURE updated 7/25/2023, revealed .Any form of resident/patient abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services will not be tolerated .It is the responsibility of all employees to report resident/patient abuse . Patients will not be subjected to abuse by anyone including staff, other patients, consultants, or volunteers, contract employees or staff from other agencies serving our patients, family members, or legal guardians, friends, or other individuals .All patients will be protected from any and all forms of abuse, mistreatment, neglect, misappropriation, exploitation, or deprivation of goods and/or services .PREVENTION .The Administrator or designee will request verification from the contracting agency or entity of the contract employee/agency personnel's compliance with required background screening and license/certification verification .The Administrator or designee will ensure the contract employee or agency personnel is without and unemployable criminal history and licensure/certification is in good standing .REPORTING AND INVESTIGATING .The person(s) observing the incident of patient abuse or suspecting patient abuse must immediately ensure patient safety then immediately report such incidents to their immediate supervisor and/or the charge nurse .The Administrator or Director of Nursing will then ensure the safety of the patient, begin the investigation, and if necessary, report information to the police . Review of the facility policy titled, USE OF RESTRAINTS, dated 9/28/2022, revealed .Each patient has the right to be free from physical restraints imposed for purposes of discipline or convenience . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Osteomyelitis of vertebra and sacrococcygeal region, Pressure ulcer of sacral region, stage 4, Parkinson's disease without dyskinesia, and Encephalopathy. Review of the 5-Day Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 revealed, a BIMS score of 8 which indicated moderate cognitive impairment. Review of Comprehensive Care Plan for Resident #1 revealed, .8/5/2024 .Alteration in mood status: ANXIETY .8/15/2024 .Patient has identified history of TRAUMA .previous abusive situation at previous SNF and PTSD from this . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation dated 8/20/2024, revealed the DON was notified of the allegation of abuse by FM H on 8/20/2024. FM H was on speaker phone when she heard the private sitter yell at Resident #1 as he attempted to try to get up from the bed. FM H called the private sitter to try to calm her down but had no success. FM H called FM N and he an attempt to call and speak with the private sitter, but she (private sitter) continued to yell and voice her concern about having the right to defend herself. FM H called the private sitter back and asked her to leave. The private sitter refused at that time but did eventually leave. The DON notified the Administrator, and she (Administrator) initiated an investigation. Continued interview revealed the allegation of abuse was substantiated. During an interview on 9/4/2024 at 4:05 PM, the Administrator stated she was the abuse coordinator. The DON was her backup abuse coordinator. The staff were trained on abuse upon hire, monthly, with any abuse allegation, and annually. She stated she was responsible to report abuse allegations to the state agency within 2 hours of the incident and then do an investigation. She stated the facility found the abuse allegation involving Resident #1 to be substantiated. Continued interview revealed, the Administrator did not notify the police about the allegation of abuse. When asked why the police was not notified, the Administrator stated, .I do not have to report verbal abuse .That is what I substantiated . Further interview revealed the Administrator did not interview the phlebotomist or LPN Q, who was the night nurse on 8/18/2024. Review of the facility investigation dated 8/20/2024, revealed the Director of Nursing (DON) stated, On 8/20/2024, [named Family Member H] [FM] reported Resident #1 had been yelled at and physically restrained on 8/18/2024 .FM H reported she was on speaker phone with Resident #1 .He [Resident #1] tried to stand up the bed .[named private sitter] tried to get him [Resident #1] to sit back down .she [FM H] heard the private sitter yelling at him [Resident #1] .FM H called the private sitter to try to calm her down .the private sitter continued to yell and be belligerent .she [private sitter] said she had the right to defend herself . FM N called the private sitter to attempt to speak with her and calm her down .she [FM H] said the private sitter yelled at [named FM N] also .FM H called the private sitter back to ask her to leave .the private sitter refused .FM H called the facility to have the private sitter removed . Continued review revealed the DON notified the Administrator of the allegation of abuse .the Administrator reported to the Ombudsman and the State Agency .the Administrator substantiated the abuse. During an interview on 9/4/2024 at 4:05 PM, the Administrator stated she was the Abuse Coordinator and responsible for reporting and investigating the allegation of abuse. She stated an allegation of abuse was to be reported to the state agency no later than 2 hours after the incident. During an interview on 9/5/2024 at 10:52 AM, LPN G was asked to recall the incident she witnessed on 8/18/2024. LPN G stated the incident occurred on a Sunday. Resident #1 had experienced a change in condition over the weekend, becoming more combative. The physician was called, and labs were ordered. The phlebotomist came to obtain the blood the same afternoon. When the phlebotomist arrived, the private sitter was in the room with Resident #1. Shortly afterwards, the phlebotomist came to me and reported she was unable to obtain the blood sample and Resident #1 had hit and bit her. LPN G stated she called FM H to get permission to give Resident #1 his prn [as needed] antianxiety medication. When LPN G entered Resident #1's room, she observed the private sitter holding his arms down across his body. LPN G told the private sitter not to do that and she [private sitter] stated, .He hit me too . When asked if the private sitter was asked to leave, LPN G stated, .The family asked [named private sitter] to leave and she left about an hour before her shift ended . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/2024 at 4:18 PM, the Clinical Nurse Manager (CNM) stated she an RN K did a phone interview on 9/4/2024 with LPN G about the allegation of abuse. The CNM reported LPN G stated she entered Resident #1 ' s room and found the private sitter holding his arms down to obtain blood while FM H was on the speaker phone. During a telephone interview on 9/5/2024 at 4:28 PM, RN K, who was on the phone with the CNM and LPN G, stated LPN G stated she walked into Resident #1's room and saw the private sitter holding both wrists down bedside Resident #1's body. RN K stated she asked LPN G why she did not report what she witnessed, and LPN G responded, .I did not think it was abuse and was more concerned with getting his blood . During an interview on 9/9/2024 at 10:13 AM, FM H stated LPN G had called her to see if she could calm down Resident #1. While on speaker phone, FM H heard the private sitter yelling at Resident #1. The situation escalated and FM H tried to calm down the private sitter with no success. FM H called FM N and FM N tried to call and calm down the private sitter. The private sitter continued to yell and be belligerent while speaking to both family members, who asked the private sitter to leave. The private sitter refused at first, but eventually left. FM H said she did not report the allegation of abuse to anyone until she had a meeting with the DON. FM H felt like LPN G would have reported the allegation of abuse since she was present during the activities that occurred while in the room. During an interview on 9/9/2024 at 3:30 PM, FM N stated when he tried to speak with the private sitter about Resident #1's behavior, she [private sitter] yelled and said she was not going to be hit. FM N felt the private sitter did not receive his feedback and hung up the phone. During a telephone interview on 9/25/2024 at 2:35 PM, the Senior [NAME] President (VP) for (named) lab and the phlebotomist were on a conference call and was asked to recall the events on 8/18/2024 involving Resident #1. The phlebotomist stated she went into Resident #1's room and saw he had some confusion. She attempted the venipuncture when Resident #1 became combative. The phlebotomist stated she put Resident #1's right arm between her legs and the private sitter held down his left arm across his abdomen/chest area but still could not obtain the blood. The phlebotomist went to LPN G and reported she was unable to obtain the blood. When asked is resident #1 refused care, the phlebotomist stated, .He [Resident #1] was yelling 'No' the whole time . During a telephone interview on 9/26/2024 at 4:47 PM, the phlebotomist was asked if Resident #1 had the right to refuse the treatment she tried to give and she stated, Yes. During an interview on 9/30/2024 at 11:56 AM, the Administrator was asked if she interviewed all parties involved in the allegation of abuse, including the phlebotomist. She responded, .I did not interview the lab person [phlebotomist] .I was not sure if she was even in the room at that time . During an interview on 10/1/2024 at 10:23 AM, LPN Q was asked if the Administrator ever interviewed her about the allegation of abuse since she was the night nurse on 8/18/2024. LPN Q stated, No. I was not interviewed. During an interview on 10/2/2024 at 12:10 PM, the DON was asked if she had interviewed the phlebotomist during the investigation. The DON stated, I did not personally interview her [phlebotomist]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's failure to do a thorough investigation of the allegation of abuse/physical restraint of Resident #1, increased the likelihood that additional abuse could occur and compromise or impede the protection of all residents residing in the facility.