STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445448	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Clarksville	198 Old Farmer Road Clarksville, TN 37043

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, medical record review, observation, and interview, the facility failed to provide care and services to promote dignity for 1 of 5 (Resident #36) sampled residents reviewed for activity of daily living (ADL) care when they failed to provide hair care. The findings include: 1. Review of the facility policy titled, Resident Rights, dated 1/31/25, revealed .All residents have the right to be treated with respect and dignity. These rights will be promoted and protected by the facility .All residents will be treated in a manner and in an environment that promotes maintenance and enhancement of quality of life. When providing care and services, the stockholders will respect the resident's individuality and value their input by providing them a dignified existence, through self-determination and communication with the access to persons and services inside and outside the facility .The facility will make every effort to support each resident in exercising his/her right to assure that the resident is always treated with respect, kindness and dignity . 2. Review of the medical record revealed Resident #36 was admitted to the facility 2/27/2025 with diagnoses including Osteomyelitis, Anxiety, Paraplegia, Pressure Ulcer Stage 4 to Sacrum, Neuromuscular Dysfunction of bladder, Spina Bifida, and the Need for Assistance with personal care. Review of the admission Minimum Data Set, dated [DATE], revealed Resident #36 had a Brief Interview for Mental Status score of 15, indicating the resident was cognitively intact, had impairment on one side of the lower extremities, required supervision or touching assistance with eating and dental care, was dependent on staff for moderate assistance of toileting, showering, dressing, and personal hygiene, required maximal staff assistance for rolling left and right, sitting to lying, lying to sitting, and was dependent on staff for chair to bed transfer. Review of the Care Plan dated 2/28/2025, revealed .Resident has a self-care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of ADL care, paraplegia, spinal rod, spina bifida, pain, ulcers, infection . Provide the amount of assistance resident needs for completion of ADL care . (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview in Resident #36's room on 5/21/2025 at 11:00 AM, Resident #36 was lying in bed on her back with her hair pulled up on top of her head in a hair clip. Resident #36's hair was matted from the nape of her neck to the top of her head with an oily appearance. Resident #36 was asked did staff assist and provide her with baths, brushing her teeth, and assist with washing and grooming her hair. Resident #36 stated .I am supposed to get a bed bath twice a week but sometimes that doesn't happen . I have only got my hair washed one time since I've been here .it is so matted and tangled they can't comb it . me and my mom have asked .to cut the matted hair out .she [Director of Nursing (DON)] told us that it was not in her scope of practice to cut my hair and that she could not cut it .I can't sleep properly with this hump [matted hair] in the back of my head .I have to sleep with my head turned to the side. During an interview on 5/22/2025 at 4:00 PM, the DON confirmed Resident #36's hair was matted to her head and had not been maintained by washing or combing it. The DON confirmed that Resident #36 and Resident #36's mother had requested staff to cut (the matted hair) her hair. The DON stated .I know she has matted hair .we don't have the clippers nor a barber here to cut it .and I told them this when they asked me about it . During an interview on 5/22/25 at 5:00 PM, Certified Nursing Assistant (CNA) E was asked is hair grooming and hair washing a part of the ADL care for Resident #36. CNA E stated .yes, it is .I do not wash or brush her [Resident #36] hair .it is tangled and matted all over .don't know if the hair can be detangled . During an interview on 5/28/25 at 7:31 PM, the Administrator was asked who is responsible for ensuring that residents' dignity and rights are maintained or enhanced. The Administrator stated .I am [the Administrator] .

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify each resident of certain balances and convey resident funds upon discharge, eviction, or death. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of resident trust accounts, policy review, medical record review, and interview, the facility failed to notify the family and/or resident when the amount in the residents' account exceeded the eligibility limit for 2 of 20 (Resident #2 and #31) residents personal fund account statements reviewed. The findings include: 1. Review of the facility policy titled Resident Trust Fund, dated 3/26/2024, revealed .facilities are entrusted with holding, handling, and tracking certain monetary funds belonging to its residents, per their written requests .facility has an established Resident Trust Fund (RTF) .desires to ensure that at all time; all funds deposited into a facility's RTF are appropriately earmarked and tracked for each resident .safeguarded as per Federal and State Regulations and Facility Policy and Procedure .The resident and/or the resident's authorized legal representative must be notified when a resident's RTF account is within $200.00 of exceeding the permitted limit, in addition to any other State Regulation requirements. To satisfy this notice requirement, the Business Office Manager should print the $200 form Notice Letter from National Data Care, obtain the Administrator's signature on same, obtain the Resident's acknowledgement of receipt of such letter (if applicable), and then place a copy of the letter in the facility's Financial Folder. If the resident is unable to sign the acknowledgement, the letter should be sent to the resident's authorized legal representative for completion .If resident is not enrolled in RFMS [Resident Trust Fund Services], the BOM [Business Office Manager] or ABOM [Assistant Business Office Manager] should enroll the resident in RFMS with the auto transfer turned on .Select the desired resident .Enter in the Debit Amount Range fields .$100. 00 to $3000.00 if the resident is a Medicaid Resident .$100.00 to $5000.00 if the resident is a Private Pay Resident .Handling monetary property for our residents is a very serious responsibility . 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Cerebral Palsy, Anxiety, Schizoaffective Disorder, Diabetes, Seizures, and Pain. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 had severe cognitive impairment. Review of the facility's Resident Fund Statement for Resident #2 revealed the Quarterly Statement for the period dated 10/30/2024 - 12/31/2024 had a balance of $4180 .09 and the Quarterly Statement for the period dated 1/1/2025 thru 3/31/2025 had a balance of $4375.49. 3. Review of the medical record review revealed Resident #31 was admitted to the facility on [DATE], with diagnoses including Diabetes, Cellulitis Bilateral Legs, Edema, and Venous Insufficiency. Review of the annual MDS dated [DATE], revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated moderate cognitive impairment. Review of the facility's Resident Fund Statement for Resident #31 revealed the Quarterly Statement for the period dated 10/30/2024 - 12/31/2024 listed a balance of $6085.51 and the Quarterly Statement for the period dated 1/1/2025 thru 3/31/2025 listed a balance of $6283.72. (continued on next page)

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F 0569 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 11:05 AM, the Business Office Manager (BOM), was asked what's the maximum amount allowed in the resident trust funds. The BOM stated, Two thousand dollars .If the amount is over that, the resident could potentially lose their Medicaid funds . The BOM was asked why the 2 accounts are so high. The BOM stated, I don't know, the family has been sent the 200 dollar letter stating they could potentially lose their Medicaid, and the families are to spend down. The BOM presented two letters that documented Resident #2 and #31 were $200 from the allowed amount, but no documentation was provided that the Residents' families had received a letter.

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F 0609 Level of Harm - Minimal harm or potential for actual harm 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** Based on facility policy review, medical record review, facility documentation review, and interview, the facility failed to report alleged violations involving abuse and injury of unknown source for 2 of 19 (Resident #28 and #82) sampled residents reviewed. The findings include: 1. Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, with a review date of 1/31/2025, revealed .It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknow origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State Law .Abuse .Is defined as the willful infliction of injury .intimidation, or punishment with resulting physical harm .or mental anguish .Physical abuse Includes, but is not limited to, hitting, slapping . controlling behavior through corporal punishment, or any similar touching of a resident that does not have an appropriate therapeutic purpose, and that is not reasonably related to the appropriate provision of ordered care and services .Injury of Unknown Source .This means an injury that meets both of the following conditions: (1) the source of the injury was not observed by any person, or the source of the injury could not be explained by the resident; and (2) the injury is suspicious because of the extent of the injury; or the location of the injury (for instance, the injury is located in an area not generally vulnerable to trauma) .Such occurrences will be investigated by the Administrator, Director of Nursing, or designee as outlined below in the investigation guidelines .Serious Bodily Injury .is defined as an injury involving extreme physical pain . involving the protracted loss or impairment of the function of a bodily member .or requiring intervention such as surgery, hospitalization . 2. Review of the medical record revealed Resident #28 admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including Displaced Bimalleolar Fracture (both of the bony knobs on the inside and outside of the ankle are broken) of Left Lower leg, Metabolic Encephalopathy, Abnormalities of Gait and Mobility, Dementia, and History of Falling. Review of the Progress Note dated 3/12/2025, revealed .Resident returned via stretcher by 2 EMS [Emergency Medical Services] personnel from [Hospital #1] .Resident was free form [from] skin tears . Resident is incontinent of bowel and bladder. Resident was placed on bed and left safe and comfortable with call light in reach . Review of the admission Observation dated 3/12/2025, revealed the Assistant Director of Nursing (ADON) noted on 3/16/2025 an observation of normal skin color. Continued review under history of the admission Observation, revealed the ADON noted on 4/2/2025, .bruise noted to left leg . This note was added after the resident had been discharged to the hospital on 3/25/2025 for the fractured ankle. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nursing Leader Wound assessment dated [DATE], revealed the Director of Nursing (DON) noted on 4/2/2025 .skin assessment .location of bruise left extremity .ankle yellow green This note was added after the resident had been discharged to the hospital on 3/25/2025 for the fractured ankle. Review of the Progress Note dated 3/13/2025, revealed .Blanchable redness to the gluteal fold to bilateral buttocks, approximately 18 cm x 30 cm no open areas noted . The admission progress note did not reflect a bruise on Resident #28's left ankle. Review of the Physical Therapy Treatment Encounter Note(s) dated 3/13/2025, revealed .Patient is able to perform bed mobility with [NAME] [Maximum Assistance] .with cues for safety and sequencing. Patient is able to perform functional transfer sit<> stand with TD [Touch-Down Weight Bearing] .from EOB [Edge of Bed] .She is able to sit EOB for about 5mins [minutes] with list to the left requiring Max A. Pt [patient] engages in supine range and endurance activities to BLE [Bilateral Lower Extremities] with tactile and verbal cues .Response to Session Interventions: actively participates with skilled interventions . Review of the Physical Therapy Treatment Encounter Note(s) dated 3/17/2025, revealed .Pt. sleeping during 2 attempts for treatment, with pt. non-responsive to name or light .remaining asleep. At following attempt for tx [treatment] during lunch, bed repositioned with HOB [Head of Bed] elevated and use music to facilitate increased alertness in order to eat. Pt becoming alert and able to engage in assisted dining with attending CAN [Certified Nursing Assistant]. Pt returning to room approx [approximately] 1.5 hours later, at which time, pt had returned back to sleep, unable to keep eyes open when name called . Review of the significant change MDS dated [DATE], revealed Resident #28 had a Staff Assessment for Mental Status which revealed the resident had poor short term and long-term memory. Resident #28 was dependent for toileting hygiene, lower body dressing, substantial/maximal assistance with personal hygiene, rolling left and right, and dependent for chair/bed-to-chair transfer. Review of Nurse Practitioner (NP) I note dated 3/24/2025, revealed .Daughter [of Resident #28] reports that patient has some bruising and swelling to left ankle that she first notice [noticed] while patient was in the hospital and was wondering if it could be gout .Area to left ankle has slight edema and slight erythema . Services Ordered .X-RAY EXAM OF LOWER LEG . Review of the Radiology Report for Resident #28 dated 3/25/2025, revealed .Results: Diffuse bone demineralization. There is a fracture present at the distal fibula above the ankle mortise with mild lateral displacement of indeterminate age. There is minimal soft tissue swelling. The ankle mortise is maintained. Conclusion: Distal fibular fracture of indeterminate age . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the History and Physical from Hospital #1 dated 3/25/2025, revealed, .[Resident #28] non ambulatory from [Named Facility #1] has xray of left ankle for swelling, facility state its fratured [fractured] without trauma of fall, pt [patient] is bed bound .hx [history] of gout .Patient is a [AGE] year-old female who presented to the ED [Emergency Department] from [Named Facility #1] nursing home with left ankle swelling which x-ray at the facility showed a fracture without known trauma, baseline bedbound for this reason patient was sent to the ED for further evaluation. On presentation, she was found to have oblique fracture [a bone break that occurs at an angle to the bone's long axis] of the distal fibula for which Dr [Doctor] .was consulted by the ED clinician, and patient's notes which I reviewed plan for left ankle fixation 3/27/25 [2025] .Oblique fracture of distal fibula, unknown etiology, per the nursing home had no known trauma . Review of an undated Witness Statement completed by Licensed Practical Nurse (LPN) H revealed, .On 3/16/25 [2025] residents [Resident #28's] daughter was talking to another staff member about her mother. I joined the conversation briefly and she was talking about her hospital visit/meds .She then mentioned her foot has a bruise and wasn't sure when or where it happened, she said she was going to come in tomorrow to talk with someone about it. I looked at her ankle/foot and saw a bruise with discoloration .around the edges . Review of an undated Witness Statement completed by Certified Nursing Assistant (CNA) K revealed, .I saw that [named Resident #28 room and bed number] had bruises on her left ankle when I came back to work on 3-14-25 [2025] . Review of an undated Witness Statement completed by LPN L revealed, .I do not recall a bruise. It may have been reported to me, but I don't recall seeing it . Review of an undated Witness Statement completed by Registered Nurse (RN) M revealed, .I am unaware of any bruising on [Named Resident #28] . Review of an undated Witness Statement completed by CNA N revealed, .I was here the day after the resident [Resident #28] came back from the hospital. I notified the nurse .She said she would make a note about the bruise on the left foot . During an interview on 5/20/25 at 8:50 AM, LPN B stated, .she [Resident #28] had went to the hospital before that x-ray .daughter wanted an x-ray done because she had a bruise on her ankle, we don't really know what happened to the ankle . During an interview on 5/20/2025 at 2:09 PM, Family Member O stated .we do not know how her ankle was broke .I was visiting [Resident #28] and the [Named CNA K] asked me if I had noticed her ankle .the ankle was black and blue swelled like a baseball .I ended up asking the PA [Physician Assistant] to get an x-ray then the DON [Director of Nursing] called me and said we going to send her to the hospital because something is going on with the ankle .I was at the hospital with [Resident #28] her ankle was not like that at the hospital . During an interview on 5/21/25 at 9:49 AM, the Regional Nurse stated, I have a soft file on an incident that the resident [Resident #28] had I will make you a copy of that report. The witness statements were noted in the investigation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/2025 at 9:35 AM, Rehab Director Q was asked if she observed a bruise to Resident #28's left ankle. Rehab Director Q stated, .I don't recall a bruise on her ankle .if I had noticed one, I would have reported it . During an interview on 5/23/25 at 9:49 AM, Physical Therapist (PT) R stated, .if I had seen a bruise to her [Resident #28] left ankle .I would report it and note it and tell the nurse .I was never asked about her fracture to her ankle .I saw her on the 17th .I don't recall any injuries during that time . During an interview on 5/23/2025 at 10:05 AM, CNA K stated, .we was in the room together daughter was here .I was doing patient care and I noticed her [Resident #28] left ankle .around the ankle above the foot . swelled and the color purple faded color .I know it wasn't the 14th it was either the 15 or 16th .daughter did not know what happened .no one in the building knew where it came from .I did fill out a witness statement .I am sure I told the nurse on the hall .I wasn't around when the daughter spoke to the NP .DON just asked me to do the witness statement .just because no one knew where it came from . CNA K was asked to review her written statement. CNA K stated, .I know it wasn't 3/14/2025 because I didn't work that date .I don't think I put that date on the statement form . During an interview on 5/23/25 at 10:41AM, LPN S stated, .[Resident #28's] daughter wasn't sure how it [left ankle fracture] happened .the daughter never told me she had a bruise at the hospital .I never seen a bruise on her ankle . During an interview on 5/23/25 at 11:30 AM, the MDS RN stated, .I was aware of the fracture to her [Resident #28] ankle . The MDS RN was asked if the facility knew how it happened. The MDS RN stated, . not that I am aware of . During a telephone interview on 5/23/2025 at 8:36 AM, Family Member O was asked again if she observed a bruise on (Resident #28)'s ankle while at the hospital. Family Member O stated, .I did not notice it at all, the CNA brought it to my attention .I did not tell the NP it was present at the hospital .the CNA was giving her bath and she seen it .I asked if she had been gotten up .the hospital never called me about an incident at the hospital .I just couldn't believe how big the bruise was, black and blue, her whole ankle all the way around and the whole thing was swelled . During an interview on 5/23/2025 at 5:30 PM, the DON was asked to review the admission Observation dated 3/12/2025, for Resident #28. The DON confirmed the ADON documented the bruise on 4/2/2025. The DON was asked to review the Nursing Leader Wound assessment dated [DATE], for Resident #28. The DON confirmed she had documented the bruise on 4/2/2025. The DON was asked why she noted this after Resident #28 was discharged . The DON stated, .I don't know, I don't know what date she discharged . The DON was asked why the facility performed an investigation for Resident #28's fracture. The DON stated, .it was a fracture .at that point we didn't know .I reported it to the Administrator . The DON was asked if the injury was reported to the state agency. The DON stated, .I am not sure if it was reported . During an interview on 5/23/2025 at 6:00 PM, the Administrator was asked if she reported the injury of unknown origin to the state agency. The Administrator stated, .no, because we felt it happened at the hospital . The Administrator was asked if she had any report from the hospital which revealed Resident #28 was involved in an accident. The Administrator stated, .No . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of the medical record revealed Resident #82 was admitted on [DATE], with diagnoses which included Hemiplegia and Hemiparesis, Cerebral Infarction, Memory Deficit, Restlessness and Agitation, Aphasia, Personal History of Traumatic Brain Injury, and Generalized Anxiety Disorder. Review of the admission MDS dated [DATE], revealed Resident #82 had a BIMS score of 4 which indicated severe cognitive impairment. Review of the care plan for Resident #82 dated 5/10/2025, revealed .Problem: Resident demonstrates inappropriate behaviors with his visitors including cussing, saying inappropriate things to others, hitting . Approach: Observe for triggers of inappropriate behaviors with residents [resident's] visitors and alter environment as needed .Approach: Assist resident away from other residents and his visitors as needed . Review of the Summary of Investigation for Resident #82 dated 5/10/2025, revealed .On May 10th, 2025, the Social Worker .stated that she was outside with [Named Resident #82] along with his significant other and her family member .significant other informed him that he would not be able to come back home for some time .[Named Resident #82] became verbally aggressive towards his significant other .the family member swatted at [Resident #82] chest .[Named Social Worker] states that she separated the two and then told them that they couldn't hit each other .The significant other and her family member left the facility .[Named Social Worker] brought [Resident #82] back into the building care plan was updated to reflect his family relationship dynamics .[Named Administrator] explained to [Resident #82] that he and his girlfriend could not argue and hit each other .[Resident #82] will be followed by psych services for mood. The facility investigation determined that no abuse occurred . Review of the Behavioral Health PROGRESS NOTE dated 5/12/2025, revealed .Resident [#82] had impaired cognitive skills as evidenced by decision making challenges and challenges with his memory related to hx [history] of TBI [Traumatic Brain Injury] and CVA [Cerebrovascular Accident]. Resident is at an overall risk for decline in psychosocial well-being due to his health .During session resident presented as cooperative and engaged .Per staff, Resident had challenges with interpersonal dynamics over the weekend. Resident stated that he was hungry and had a disagreement with his partner due to wanting her to bring him food .Resident denied any safety issues/concerns .Overall, resident's cognitive performance fell in the moderate range of impairment. Their [Resident #82] memory performance was impaired, as evidenced by a Delayed Recall Score [measures how much information is remembered after a delay] of 0/3 . During an interview on 05/21/2025 at 10:55 AM, the Social Worker stated, .Family member hit him while he was outside, I witnessed it, I immediately intervened, open hand hit, chest area .I don't know her name, I got between both of them and brought him back inside, I told the visitor she was not allowed to put her hands on him .the visitor said she hit because he made some inappropriate remarks to her .He said he was fine and psych [the Licensed Clinical Social Worker] seen him on the following Monday, it happened on a Saturday, 5/10/2025, I did not consider that physical abuse .I told her she is not allowed to put her hands on the resident, I reported it to the Administrator and the Director of Nursing (DON). The Social Worker was asked why she did not consider that physical abuse. The Social Worker stated, .it was an open hand tap . The Social Worker was asked if any changes were made to limit his visitation with his family after the incident. The Social Worker stated, .I have not seen them since the incident, I am not sure about the visitation access for these visitors . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/21/25 at 11:12 AM, the DON was asked if Resident #82 had any issues with a visitor and was she aware a visitor hit the resident. The DON stated, .no issues that I know of .I don't know anything about a visitor hitting him, no one ever reported to me concerns about a visitor . The DON was asked if Resident #82 was alert and oriented and able to make sound decisions. The DON stated, .at times I think he is cognitively accurate . During an interview on 5/23/2025 at 12:08 PM, the MDS RN was asked who added the care plan for resident demonstrates inappropriate behaviors for Resident #82. The MDS RN stated, .SSD [Social Services Director] added it to the care plan, I don't know why it was added . The MDS RN reviewed SSD notes and stated, .I don't see anything about why it was added . During an interview on 5/23/25 at 3:35 PM, the Licensed Clinical Social Worker stated, .on 5/12/2025 SSD [the Social Worker] had asked me to see him because he had a disagreement with his girlfriend .he told me it was a verbal disagreement .it was not reported to me that he was hit .he has moderate cognitive impairment . During an interview on 5/23/2025 at 5:30 PM, the Administrator was asked if she reported the incident of Resident #82 being hit by his visitor to the state agency. The Administrator stated, No, because I talked to him, and he said he didn't feel abused. The Administrator was asked if a resident with a BIMS score of 4 could make an accurate recall if he experienced abuse. The Administrator stated, .he talks to me all the time, I thought he could make that decision .

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	445448	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Clarksville	198 Old Farmer Road Clarksville, TN 37043

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, fall investigation review, medical record review, observation, and interview, the facility failed to ensure a safe and secure environment for 5 of 7 (Resident #31, #50, #248, #498 and #501) sampled residents reviewed for falls and accidents. The facility failed to ensure processes were implemented to provide supervision and assistance to ensure the residents' environment was free of accident hazards. The facility failed to conduct thorough fall investigations to identify all contributing factors (root causes) and failed to implement appropriate interventions to ensure resident safety. Resident #498 was admitted on [DATE] and had 13 falls from [DATE] through [DATE]. On [DATE], Resident #498 sustained 3 falls, that resulted in a subdural hemorrhage, a C5 fracture (cervical neck fracture) and bilateral rib fractures. Resident #498 was sent to the emergency room (ER), was admitted to the hospital and discharged back to the facility on [DATE]. Resident #498 was a vulnerable Resident with memory impairment and abnormalities of gait and mobility. The facility's failure to provide supervision and ensure a safe environment free of accident hazards resulted in Immediate Jeopardy for Resident #498. Immediate Jeopardy (IJ) (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) was identified related to the facility's failure to use its resources effectively to attain and maintain the highest practicable well-being of vulnerable residents, to ensure systems and processes were implemented to provide supervision and assistance to ensure the resident environment was free of accident hazards. The Administrator was notified of the Immediate Jeopardy (IJ) for F-689 during the recertification/complaint investigation on [DATE] at 6:48 PM, in the Conference Room. The facility was cited at F-689, at a scope and severity of J which is Substandard Quality of Care. The Immediate Jeopardy existed from [DATE]-[DATE]. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 2:42 PM, with an alleged removal date of [DATE]. The Removal Plan was verified and validated onsite by the surveyors on [DATE] through review of the in-service training records and audits, review of the facility's policy, observations, and staff interviews. The last day of the IJ was [DATE]. The IJ was removed on [DATE]. After the acceptable Removal Plan for F-689 was validated on [DATE], noncompliance remains for F-689 at a scope and severity of D. The facility is required to submit a Plan of Correction. The findings include: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	1. Review of the facility's policy titled, Falls, with a revision date of [DATE], revealed .The intent of this policy is to ensure the facility provides an environment that is as free from accident hazards, as possible, over which the facility has control to prevent avoidable falls .All residents will have a fall risk assessment on admission/readmission, quarterly, annually, and with a significant change of condition to identify risk for falls . A Comprehensive Care Plan will be implemented based on the resident's risk for falls with an individual goal and interventions specific to each resident to attempt to reduce the risk of avoidable falls .Care Plan Accidents goals and interventions will be revised as applicable .The Interdisciplinary Team (IDT) which includes the Director of Nursing (DON) or their designee reviews during the At-Risk Meeting .Falls may be reviewed at the facility Quality Assurance/Performance Improvement (QAPI) Committee . Review of the facility's policy titled, Accidents and Incidents, with a revision date of [DATE], revealed .The intent is to ensure the facility provides an environment that is as free from accidents and incidents that are avoidable, the facility investigates these occurrences with applicable documentation, and appropriate reporting is completed as applicable .The Nurse, Nurse Supervisor/Charge Nurse and /or the Department Director of Supervisor shall initiate and document the accident or incident . Review of the facility's document titled, Neuro Check Guidelines, dated [DATE], revealed .Witnessed Fall- No Head injury / did not Hit Their Head .Complete fall event in MatrixCare .Neuro checks not needed- follow provider orders .Continue charting on resident for 72 hours .Unwitnessed Fall or Witnessed Fall With Head Injury / Hit Their Head .Complete fall event in MatrixCare .Neuro checks every 15 minutes x [times] 4 (total of 1 hour) .Neuro checks every 30 minutes x 2 (total of 1 hour) .Neuro checks every 1 hour x 4 (total of 4 hours) .Neuro every 4 hours x 4 (total of 16 hours) .Resume routine charting for the remainder of the 72 hours post fall . 2. Review of the medical record revealed Resident #498 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses including Traumatic Subarachnoid Hemorrhage, End Stage Renal Disease (ESRD), Osteoporosis, Epistaxis, Malignant Neoplasms of Lymphoid, Hematopoietic, and related Tissues [group of cancers that affect blood cells and the tissues of the lymphatic system], Chronic Obstructive Pulmonary Disease (COPD), Pulmonary Fibrosis, and Dementia. Review of the facility's Event Report dated [DATE], revealed Resident #498 had an unwitnessed fall at 10:35 AM. Resident #498's Fall Risk Score was 21 indicating the Resident was at a high fall risk. Staff documented following the Resident's fall that the Resident's pupils were 3 mm [millimeters] and Neuro Checks were completed as follows: Three (3) Neuro checks were performed every 15 minutes (not 4 every 15 minutes), Two (2) Neuro checks were performed every 30 minutes, One Neuro check was performed once for 1 hour (should have been every hour for 4 hours then every 4 hours times 4 for a total of 16 hours). Review of the Progress Note dated [DATE] at 6:25 PM, revealed Unwitnessed fall noted this shift. Resident confused and doesn't know why she was walking. No pain noted or reported . This was fall #1. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Care Plan dated [DATE] revealed .Falls Resident at risk for falling R/T [related to] history of falls, impaired cognition, medications, ESRD, dementia, COPD, arthritis, pain, cancer, unsteady, poor safety awareness . Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #498 had a Brief Interview for Mental Status (BIMS) score of 2, which indicated severe cognitive impairment. Resident #498 had 1 fall with no injury documented. Review of the progress note dated [DATE] at 2:30 PM, revealed Resident [#498] was seen crawling into the main hallway by CNA [Certified Nursing Assistant], resident refused to verbalize what occurred prior to CNA finding pt [patient] crawling on the floor, resident did not sustain any visible injuries and neuro [neurological] & cognitive sts [status] remain at baseline, no s/s [signs/symptoms] or c/o [complaint of] pain, resident was holding their chest and appeared to be SOB [short of breath], O2 [oxygen] sat [saturation] at time of incident was 84% [percentage symbol][normal oxygen sat is 95% - 100%], applied 1L [Liter] O2 and current sat. is 99% while on 1L O2 via [by way of] NC [nasal cannula], all other vitals at this time are WNL [within normal limits]. This was fall #2. Review of the progress note dated [DATE], revealed IDT [Interdisciplinary Team] Review: Resident [#498] sustained a fall without acute or latent injury on [DATE] Root Cause: [Named Resident #498] is at risk for falls related to impaired cognition and mobility per the comprehensive plan of care. Resident sustained fall on [DATE] without injury Intervention: Resident to be encouraged to remain in communal areas when possible. Discussed in AM clinical with no further recommendations offered at this time . Resident #498's BIMS score was 2, indicating severe cognitive impairment. The facility failed to complete neuro checks according to the neuro check guide after one hour following the unwitnessed fall on [DATE]. Vital signs were obtained at 2:30 PM and 2:45 PM. Neuro checks were completed every 15 minutes x 4 then stopped. Review of the facility's Event Report dated [DATE] at 10:40 PM, revealed Observed in the floor .[checked] Witnessed [fall] and did not hit her head . This was fall #3. The facility failed to identify this fall where Resident #498 was observed in the floor as an unwitnessed fall and no neuro checks were completed. The intervention implemented after this fall was a fall mat by the bed. Review of the progress note dated [DATE] revealed IDT Review: Resident sustained two falls without acute or latent injury on [DATE]. Resident #498 sustained two falls on [DATE] and the facility was unable to provide fall investigations for the 2 falls on the [DATE]. This was fall #4 and #5. Review of the Progress Note dated [DATE] at 1:44 PM, revealed Unwitnessed fall noted this shift. Resident confused and attempted to get out of bed. 5/10 pain reported . This was fall #6. Review of the care plan intervention for the Resident's falls dated [DATE], revealed, . fall mat to left side of bed . The facility failed to complete neuro checks according to the neuro check guide for this unwitnessed fall. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the facility's Event Report dated [DATE], revealed .unwitnessed fall .Fall Risk Assessment 17 High fall risk . Review of the progress note dated [DATE] at 12:39 AM, revealed Resident had an unwitnessed fall approximately 1900 [7:00 PM] in hallway 200. Vitals obtained were 96.9 [Temperature (T)], 134/78 [Blood Pressure (BP)], 82 [Pulse (P)], 98% [O2 sat] room air. Resident was on the fall [floor] with her head near the wall. Unsure if she hit her head. She was ambulating with the walker. Called DON [Director of Nursing] and reported the fall. Started neuro checks .Staff was able get resident to sit in the geri chair [a type of reclining chair] for just a little time before she climbed out and fell again about 19:45 [7:45 PM] .transferred resident [to the hospital] . This is fall #7. The facility failed to complete neuro checks according to the neuro check guide and failed to complete vital signs. Review of the progress note dated [DATE] at 5:42 PM, revealed While staff was attempting to assist resident, she quickly sat herself in the floor 'indian style' .Assisted with rising per one staff and much encouragement, res [Resident] quickly squatted in the floor . This is fall #8. Review of the Care plan intervention for the Resident's fall dated [DATE] revealed, .keep w/c [wheelchair] within reach at bedside .therapy eval [evaluation] for use of walker . Review of the progress note dated [DATE] at 2:06 PM, revealed resident [#498] continues on alert charting for monitoring falls resident had a fall on [DATE] no latent injury no neuro checks requested at this time no behaviors noted on this shift resident vitals remain WNL [within normal limits] . Interview revealed Resident #502 informed staff that Resident #498 was in the floor. Resident #502 no longer resided in the facility. See the Director of Nursing (DON) interview on [DATE] at 5:20 PM. This was an unwitnessed fall, and no neuro checks were completed. This was fall #9. Review of the facility's Event Report dated [DATE] at 11:53 AM, revealed resident [#498] was seated in dialysis chair in common area. Resident stood up and lost her balance and fell to floor, resident did not hit her head. Safely assisted resident back to chair, resident then attempted to get up again without assistance. Vitals taken BP 105/54, P 88, R 20, no injuries observed at this time .continue neuro checks .Witnessed . This was fall #10. Review of the Care plan intervention for the Resident's fall dated [DATE] revealed .sensory device to chair . The facility documented continue neuro checks but were unable to provide neuro check documentation. Review of the progress note dated [DATE], revealed Resident [#498] sent to hospital, resident had three unassisted falls that led to head injury, and other facial bruising with complaint of pain. Want to make sure resident has no underlying issues related to the falls . This was fall #11, #12, and #13. The facility failed to complete a fall investigation, vital signs, and neuro checks for the 3 falls on [DATE] for Resident #498. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the Emergency Documentation [Hospital #1], dated [DATE], revealed .Computed Tomography [CT scan] Head or Brain . Impression . subdural hemorrhage the anterior aspect of .4.1 mm [millimeters] . Discharge Diagnosis .Recurrent Falls; Subdural bleeding . Further review revealed Resident #498 was transferred from Hospital #1 to Hospital #2 on [DATE] to follow up with neurosurgery. Review of the [Named Hospital #2] History and Exam form dated [DATE], revealed .Patient diagnosed with SDH [Subarachnoid Hemorrhage], C [cervical]-5 fracture and bilateral rib fractures .Neurosurgery is following patient for SDH . Review of the [Named Hospital #2] Trauma Surgery Discharge Summary dated [DATE], revealed Additional Discharge Diagnoses . Subarachnoid Hematoma, Unspecified fracture of fourth lumbar vertebra, subsequent encounter for fracture with routine healing, Other nondisplaced fracture of fifth cervical vertebra, subsequent encounter for fracture with routine healing, and Multiple fractures of ribs, bilateral, subsequent encounter for fracture with routine healing. Review of the progress note dated [DATE] at 16:39, revealed Rtn [returned] to facility via EMS [Emergency Medical Services] on gurney; transferred to bed by EMS; tol [tolerated] well; resident alert and oriented to self; no s/s pain observed; c [cervical]-collar in place. No skin issues noted. LS [lung sounds] clear bilat [bilateral]; BS [bowel sugar] active X [times] 4 quads [quadrants]; no edema noted; will monitor. VSS [vital signs stable] . Review of the progress note dated [DATE] at 1:04 AM, revealed resident [#498] sustained unwitnessed fall and hit her head, no injuries noted but resident was bleeding from her nose. Vitals checked T-97.8, HR-74, R-16, BP-103/58, SP02-98% RA [room air] . EMS [Emergency Medical Services] arrived and safely transferred resident from bed to stretcher via assist x2. This was fall #14. Review of the Care Plan interventions for Resident 498's falls dated [DATE], revealed, .offer sensory sound device to assist in promoting restful sleep at hs [bedtime] . Review of the NP Progress Note dated [DATE], revealed Resident #498 was admitted to inpatient services at Hospital #1 from [DATE] - [DATE].seen today following readmission to the facility .She [Resident #498] presented to the hospital following and [an] unwitnessed fall with a nosebleed .She has a C5 c-spine fracture from another fall. She was admitted for acute blood loss anemia and anemia of chronic disease. She received one unit of PRBCs [packed red blood cells] . Review of the Care Plan dated [DATE], revealed .ADLs [Activities of daily living] Functional Status/Rehabilitation Potential .Resident has a self care deficit related to impaired physical functioning and medical conditions as evidenced by the need for staff assistance for adequate completion of ADL care, weakness, impaired cognition from dementia, ESRD with dialysis, COPD with shortness of breath, rib fractures .C-Collar as ordered . Review of the quarterly MDS dated [DATE], revealed Resident #498 had a BIMS score of 00, which indicated severe cognitive impairment. No falls were documented on the assessment. Review of the Care Plan edited on [DATE], revealed .Pain .Resident has at risk for complaints of acute/chronic pain R/T [related to] ESRD with dialysis, cancer .rib fractures .Encourage resident to request pain medication PRN [as needed]. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Observations in the resident's room on [DATE] at 4:26 PM and on [DATE] at 10:52 AM revealed no fall mat in Resident #498's room and Resident #498 was in a Broda chair (a type of reclining chair) in the hallway. During an interview on [DATE] at 2:13 PM, the Administrator was asked when she presented the Roster Matrix to the surveyor to verify the facility did not have any falls with major injuries. The Administrator stated, No. The Administrator was asked to verify the facility did not have any resident falls with fractures. The Administrator stated, No, we did not. During an interview on [DATE] at 11:03 AM, CNA E was asked if she worked with Resident #498. CNA E Stated, .yes, She [Resident #498] likes to crawl out of bed and lay on the floor. In March her face had bruising, and they said she fell. She had a C collar on. She tries to remove the collar. She was out [at the hospital] when I came back [back to work from being off], and she [the Resident] returned a few days later [to the facility] .She [Resident #498] is hard to redirect and yells at you, she will swing at you at times. She needs a fall mat, I tell them [staff] all the time because she likes to lie in floor. Never seen a fall mat in her room . During an interview on [DATE] at 1:54 PM, the Regional Nurse Consultant handed the surveyor the discharge summary and history and physical and stated, I cannot find a fall investigation for [DATE]. Observation in the resident's room on [DATE] at 10:08 AM, revealed no fall mat by Resident #498's bed. During a telephone interview on [DATE] at 7:15 AM, Licensed Practical Nurse (LPN D) was asked about Resident 498's fall which occurred on [DATE]. LPN D stated, . [named CNA U] came and told me what occurred. CNA [U] was helping another resident on the hall while she found [named Resident #498] on the floor. She didn't witness the fall. LPN D was asked if she had been reprimanded for not conducting a fall investigation. LPN D stated, I did not get written up .Someone did give me a call the next day and asked me what I did .I was on the phone with the on-call NP [Nurse Practitioner] the EMS arrived. I worked as agency then, but I have not worked there since. She [DON] asked me to come in early one night and I don't recall writing a statement . During an interview on [DATE] at 10:04 AM, CNA V was asked if there was a fall mat in Resident #498's room. CNA V stated, No Ma'am, no fall mat. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 5:20 PM, the DON was asked when and how often should neuro checks be initiated. The DON stated, For unwitnessed falls, after doing a complete assessment, notify provider, family, and follow through with orders . The DON was asked what was considered a fall with major injury. The DON stated, A fracture, a SDH [subdural Hemorrhage] is a major injury. The DON was asked when should neuro checks be done. The DON stated, It's nursing 101 you know to call family and provider, look at standard of care and best practices is neuro checks. It should be at least 3 days after the fall noted in the progress notes . The DON was asked who should start the fall investigation. The DON stated, The nurse should open it, and we review it in IDT [Interdisciplinary Team] Should be opened and started at point of the fall . The DON was asked who does fall risk assessments. The DON stated, [The] Nurse on the floor and at a minimum quarterly . The DON was asked who is responsible for witness statements. The DON stated, The DON and ADON [Assistant Director of Nursing]. The DON was asked why Resident #498 and #501 were not listed on the facility's matrix as falls with major injury (FMI). The DON stated, It was on there. The surveyor showed the DON the facility's matrix that did not reflect Resident #498 and #501's fall with major injury. The DON stated, Well, that was a mistake. The DON was asked which resident observed Resident #498 on the floor on [DATE]. The DON stated, [Named Resident #502] . The DON confirmed Resident #502 no longer resided in the facility. The DON was asked why there was no fall investigation for the falls that occurred on [DATE]. The DON stated, We did one investigation for all 3 falls that day .The third fall she went out because she hit her head that time . The DON was asked should a fall mat have been in room by the bed last week. The DON stated, Yes, it was not discontinued . The DON was asked should vital signs be taken with fall investigations. The DON stated, Vital Signs are fundamental nursing 101 .They charted WNL, Stable . The Vital signs were documented as stable, but the actual vital signs were not documented. During an interview with the Assistant Director of Nursing (ADON) on [DATE] at 3:00 PM. The ADON confirmed the neurological assessments were not completed per protocol and stated there should have been more than just one for an unwitnessed fall. 2. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE], with diagnoses including Diabetes, Cellulitis Bilateral Legs, Edema, and Venous Insufficiency. Review of the annual MDS dated [DATE], revealed a BIMS score of 8, which indicated Resident #31 had moderate cognitive impairment. Resident #31 required maximum assistance of staff to perform activities of daily living (ADLs). Review of the facility's Event Report dated [DATE], revealed Resident #31 sustained an unwitnessed fall in the Resident's room. Staff performed a neuro check at 9:03 PM and at 9:15 PM. The facility failed to perform neuro checks according to the neuro check guide on Resident #31 after 9:15 PM. During an interview on [DATE] at 5:20 PM, the DON confirmed that neuro checks should be performed every 15 minutes for 1 hour, every 30 minutes x 4, every hour x 4, and every 8 hours x 2. 3. Review of the medical record revealed Resident #50 was admitted to the facility on [DATE], with diagnoses including Dementia, Diabetes, Peripheral Vascular Disease, and Hypertension.? (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the admission MDS assessment dated [DATE], revealed a BIMS score of 3, which indicated Resident #50 had severe cognitive impairment. Resident #50 required maximum staff assistance to perform toileting and bathing, and moderate staff assistance for transfers. Resident #50 had 1 fall since admission documented. Review of the facility's Event Report dated [DATE] at 5:46 PM, revealed Resident #50 sustained a witnessed fall in his room by the bedside table.Staff CNA [Certified Nursing Assistant] witnessed fall .Notes XXX[DATE] 5:54 PM .Resident had a witnessed fall and hit his head while attempting to get snacks off of his table . The facility failed to perform neuro checks according to the neuro check guide and obtain a witness statement from staff. 4. Review of the closed medical record revealed Resident #248 was admitted to the facility on [DATE], with diagnosis including Alzheimer's Disease, Chronic Obstructive Pulmonary Disease, Dementia, Acute Kidney Failure, Psychotic and Mood Disturbance, and Anxiety. Resident #248 expired [DATE]. Review of Care Plan dated [DATE], revealed .Problem: Resident at risk for falling R/T [related to]: weakness, frequent falls, dementia, COPD [Chronic Obstructive Pulmonary Disease] with shortness of breath, tremor, bradycardia, medications .2 person assist with transfers .highlighted call light .encourage to be up in communal areas .non slip material to wheelchair .bilateral fall mats .bed in lowest position .Problem: Resident has impaired cognitive skills as evidenced by: Decision making problems, Short term memory problem, dementia, takes medications with potential for side effects . Review of the admission MDS assessment dated [DATE], revealed Resident #248 had a BIMS score of 3, which indicated severe cognitive impairment. Resident #248 required maximal staff assistance for ADLs. Review of the Event Report dated [DATE], revealed .14:37 [2:47 PM] .unwitnessed fall w/o [without injury] . resident room .[Named Resident #248] Fall Risk Score Total:21 .high fall risk .Seen resident lying on foam fall mat left side of bed .Reminded resident to press call lights for needs and assistance XXX[DATE] Root Cause: .at risk for falls related to impaired cognition and impaired mobility . The facility failed to complete neuro checks after an unwitnessed fall according to the facility neuro check guide. Resident #248 had severe cognitive impairment so a reminder to press the call light for assistance was an inappropriate intervention. 5. Review of the medical record revealed Resident #501 was admitted to the facility on [DATE], with diagnoses including Atrial Fibrillation, Fractured Rib, Diabetes, and Cerebral Infarction. Review of the admission MDS assessment dated [DATE], revealed Resident #501 had a BIMS score of 10, which indicated moderate cognitive impairment. Resident #501 had 1 fall with no injury documented. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the progress note dated [DATE], revealed Fall event occurred, neuro checks in place no new injuries or concerns, redirected and encouraged to use call light and to keep bed at safe level, informed DON .Oncall Np [Nurse Practitioner], and RP family member, son .to make them aware of incident but no serious injury noted. Left voice mails with all appropriate contacts and encouraged son to know his dad is ok [okay] . Review of the facility's Event Report dated [DATE] at 1:49 AM, revealed .Fall unwitnessed .Neuro checks 11:00 PM, 11:15 PM, 11:30 PM, 11:45 PM, 12:15 AM, 12:45 AM, 1:15 AM, 2:15 AM, 2:15 AM, 3:15 AM, 4:35 AM .Fall Risk Score 16 High Fall Risk .[Named resident is at risk for falls .related to impaired mobility . The facility failed to complete neuro checks according to the facility neuro check guide. Review of the Care Plan dated [DATE] revealed Resident has a right rib fracture r/t to fall . 6. An acceptable Removal Plan, which removed the immediacy of the Jeopardy, was received on [DATE] at 2:42 PM. The surveyors validated the Removal Plan through review of the in-service training records and audits, review of the facility's policy, observations, and staff interviews. 1. Corrective Actions for identified resident(s) affected by the deficient practice. The facility failed to have a system in place to ensure the resident's environment remained as free of accidents and hazards as was possible and to ensure that the resident received adequate supervision to prevent accidents for resident #498. a. Resident #498 expired at the campus on [DATE]. b. On [DATE] at 22:42 resident was sent to the hospital after falling at the campus and obtaining a suspected head injury. Resident had documentation from the nurse in a nurse's note that the resident had 3 unassisted falls that led to head injury, facial bruising, and complaint of pain. The Director of Nursing (DON), nurse practitioner (NP), and the resident's family member were notified, and order was obtained to send to ER for evaluation. c. [DATE]: Resident was assessed at Vanderbilt hospital and was noted to have a 4mm subdural hematoma with no neurological changes, both pupils equal and reactive, and Glascow Coma Scale (GCS) was 14. Resident was confused, which is her baseline, and obeys commands. CT of the head showed small subdural hemorrhage with no visible acute infarct, contusion, hydrocephalus, or midline shift. d. (continued on next page)

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	445448	A. Building B. Wing	05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Clarksville	198 Old Farmer Road Clarksville, TN 37043

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]: Vanderbilt Discharge Summary shows that neurological exams remained stable throughout stay and she discharged from hospital to return to the campus. e. Resident returned to the campus at her baseline and returned to participation in her routine per her norm. f. [DATE]: upon the interdisciplinary teams (IDT) (Director of Nursing (DON), Assistant Director of Nursing (ADON), Social Services Director (SSD), and minimum data set coordinator (MDSC), review of records it was determined that the fall event(s) were not opened in the medical record in correlation with the assessment note. The DON and ADON immediately initiated an investigation that included interviews and education of nurses on completion of documentation. Through the investigation it was determined that each time the resident had a fall there was an intervention placed; however, the interventions did not get added into the plan of care. g. [DATE]: the Resident and her family opted to pursue hospice due to diagnosis of multiple myeloma, unrelated to fall and associated injuries from [DATE]. Hospice was initiated at this time and the resident stopped dialysis per her preference and end of life planning. Resident expired on [DATE] under the care of Hospice. 2. Identification of other residents who may be affected by the deficient practice and corrective actions that will be put in place to ensure the deficient practice does not reoccur. The facility took immediate action to ensure all residents are free from accident hazards and to ensure the residents receive adequate supervision to prevent accidents. a. [DATE]: All residents were reviewed by regional nurses and campus nurse leadership for fall risk and all resident care plans were reviewed for appropriate fall interventions. b. [DATE]: All falls since [DATE] were reviewed by regional nurses and campus clinical leadership to ensure that processes and procedures were followed per the plan of care and neuro checks were completed for unwitnessed falls and/or falls that resulted in the resident hitting their head. c. [DATE]: Resident rooms were rounded on by facility clinical leadership and regional nurses to ensure that fall interventions are in place. No concerns noted. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	d. All resident's that fall will be reviewed in clinical morning meeting by the members of the IDT (DON, ADON, MDS Coordinator (MDSC), and Social Services Director (SSD) to ensure that appropriate interventions are in place and care plans are updated. e. All residents that fall will be followed weekly in the campus At-Risk meeting to ensure interventions implemented are in place and effective. The IDT, in conjunction with the medical provider, who are reviewing weekly may make changes to the plan of care and interventions that are reviewed. 3. Measures put into place and systemic changes you will make to ensure that the deficient practice does not reoccur. a. All nurses will be re-educated on the Fall policy and completion of neurological checks for residents that have a fall and hit their head, or the fall was unwitnessed beginning 5[TRUNCATED]

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy, medical record review, observation, and interview, the facility failed to follow Physician's Orders for oxygen for 1 of 1 (Resident #14) sampled residents reviewed for respiratory care. The findings include: 1. Review of the facility policy titled, Oxygen Administration Policy, revised 1/31/2025, revealed .Oxygen therapy is administered as Ordered by a Physician .Determine appropriate oxygen source and equipment needed for Physician's Orders . Review of the facility policy titled, Physicians Orders, revised 1/31/2025, revealed .It is the standard of this facility that physicians [physician's] orders are followed, reviewed to ensure delivery of applicable care .Each resident will have physician's orders to guide the facility in caring for and treating each resident .Licensed Nurses .are expected to follow physician's orders . 2. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Anemia, Heart Failure, Dementia and Anxiety Disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 11, which indicated Resident #14 was moderately cognitively impaired, and received oxygen therapy. Review of Physician's Orders dated 5/5/2025, revealed, Oxygen via [by way of] NC [nasal cannula] @ [at] _2_Liters per minute PRN [as needed]. Review of the Medication Administration Record (MAR) dated 5/2025, revealed Resident #14 was administered Oxygen therapy via NC at 2 Liters per minute daily from 5/5/2025 through 5/20/2025. Observations in the Resident's room on 5/19/2025 at 3:28 PM and 5/21/2025 at 7:52 AM, revealed Resident #14 was receiving oxygen via NC with the oxygen concentrator set at 3 liters per minute. During an observation and interview in the resident's room on 5/21/2025 at 1:33 PM, the Director of Nursing (DON) confirmed Resident #14's oxygen concentrator was set at 2.5 liters per minute. The DON confirmed Resident #14 had a Physician's Order for oxygen at 2 liters per minute and that staff should follow physician orders.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, observation and interview, the facility failed to ensure infection control practices were followed during medication administration for 2 of 8 (Resident #8 and #22) residents observed for Medication Administration when 2 of 7 nurses (Licensed Practical Nurse (LPN) A and LPN B) failed to sanitize reusable equipment. The findings include: 1. Review of the facility policy titled, Infection Control, revised 1/31/2025, revealed .Facility infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .Provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment . 2. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Cerebral Palsy, Gastrostomy, Methicillin Resistant Staphylococcus Aureus (a bacteria that is resistant to many common antibiotics), and Seizures. Review of the annual Minimum Data Set (MDS) assessment dated [DATE], revealed staff did not perform a Brief Interview for Mental Status (BIMS) due to Resident #22 was severely cognitively impaired and had a feeding tube. Observation during medication administration on 5/20/2025 at 10:21 AM, revealed LPN C entered Resident #22's room to administer Gabapentin (medication used to treat nerve pain) 100 milligrams (mg) via (by way of) the feeding tube. LPN C used the stethoscope that was around her neck to check the resident's feeding tube placement and replaced the stethoscope around her neck. LPN C flushed the feeding tube with 43 milliliters (ml) of water via gravity, administered the medication dissolved in 30 ml of water, and flushed the tube with 100 ml of water. LPN C placed the syringe back in the package and hung the syringe on the pole without rinsing the syringe and exited the resident's room. LPN C was asked should the syringe be cleaned and rinsed after medication administration and should the stethoscope be cleaned after use on a resident. LPN C stated that the syringe is rinsed when the feeding tube is flushed with water and confirmed that the stethoscope should be cleaned after use. 3. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE], with diagnoses including Chronic Obstructive Pulmonary Disease, Diabetes, and Allergic Rhinitis. Review of the quarterly MDS assessment dated [DATE], revealed a BIMS score of 14, which indicated Resident #8 was cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation during medication administration on 5/21/2025 at 8:20 AM, revealed LPN B entered Resident #8's room to check the Resident's blood pressure prior to medication administration. LPN B checked the Resident's blood pressure with an automatic wrist cuff and placed the wrist cuff in her lab coat pocket after use. LPN B administered medications to Resident #8 and exited the Resident's room, removed the wrist cuff from her pocket and placed it on top of the medication cart. LPN B was asked if the wrist cuff should be cleansed after use. LPN B confirmed that the wrist cuff should be cleansed after use. During an interview on 5/22/2025 at 2:53 PM, the Director of Nursing (DON) confirmed that syringes should be cleansed after use during medication administration and reusable medical equipment should be sanitized after use on a resident.