STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445180	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nhc Healthcare, Lawrenceburg	374 Brink Street Lawrenceburg, TN 38464

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 35314 Based on interviews, record review, and facility policy review, the facility failed to report an allegation of potential abuse for 1 (Resident #44) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Patient Protection and Response Policy for Allegations/Incident of Abuse, Neglect, Misappropriation of Property and Exploitation, revised on 02/01/2023, revealed, It is the policy of this facility that abuse allegations are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. A Resident Face Sheet indicated the facility admitted Resident #44 on 05/19/2022, with diagnoses to include congestive heart failure, protein-calorie malnutrition, left shoulder arthritis, age-related osteoporosis, and osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #44 was dependent on staff for toileting hygiene, showering/bathing, and upper and lower body dressing; and required substantial/maximal assistance with personal hygiene and rolling left and right. Per the MDS, Resident #44 was always incontinent of bowel and bladder. Resident #44's Care Plan, with a start date of 05/20/2022, revealed the resident had a self-care deficit related to congestive heart failure, adult failure to thrive, tremors, and incontinence. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A handwritten note on a Physician's Orders form, written by Licensed Practical Nurse (LPN) #4 and dated 04/24/2024, revealed as Certified Nurse Aide (CNA) #1 provided Resident #44 a bath, the resident stated the CNA hurt them by cleaning them roughly. According to the handwritten note, a nurse spoke with the resident on 04/24/2024 to explain good perineal care. A handwritten note on a Physician's Orders form, written by LPN #4 and dated 05/02/2024, revealed Resident #44's Responsible Party (RP) called the facility and stated they did not want CNA #1 to go into Resident #44's room again due to concerns with home the CNA cleaned the resident. During an interview on 05/06/2024 at 10:20 AM, Resident #44 stated last month, CNA #1 shoved them back and forth violently. Resident #44 stated they complained enough about the CNA and now the CNA had not entered their room again. During an interview on 05/06/2024 at 10:27 AM, the Administrator stated he was not aware of any incidents that involved Resident #44. Per the Administrator, the facility had not reported any incidents regarding Resident #44 to the state agency. During an interview on 05/06/2024 at 2:37 PM, the Director of Nursing (DON) stated she was not aware of an incident in which Resident #44 reported that staff turned them violently or roughly. During an interview on 05/06/2024 at 3:28 PM, the Assistant DON stated based on an interview with the resident, staff should have notified social services or the abuse coordinator of the incident so they could determine if it was abuse. During an interview on 05/07/2024 at 1:11 PM, Resident #44's RP stated Resident #44 contacted them regarding a CNA that twisted their legs and hit their head against the bed. The RP stated Resident #44 did not want the CNA to care for them again. According to the RP, they did not inform the nurse of the resident's allegation. During an interview on 05/08/2024 at 11:04 AM, LPN #4 stated on 04/24/2024, CNA #1 came out of Resident #44's room and informed her that Resident #44 was upset with her. LPN #4 stated she went into Resident #44's room and the resident told her that CNA #1 had been rough. LPN #4 stated she did not notify anyone about Resident #44's statement and there was no documented evidence of any further action that was taken to investigate the resident's concerns. According to LPN #4, she spoke with Resident #44's RP on 05/02/2024 and the RP stated they did not want CNA #1 to provide care to Resident #44 anymore. LPN #4 stated she notified the Director of Nursing (DON) on 05/02/2024 of the RP's wishes for CNA #1 not to work with the resident anymore. During a follow-up interview on 05/08/2024 at 12:54 PM, the DON stated after Resident #44's RP called the facility, LPN #4 notified her that the RP did not want CNA #1 to provide care to Resident #44 anymore. The DON stated LPN #4 only informed her there were issues with perineal care, which the DON stated she did not feel was abusive. However, the DON stated, if staff were rough, the facility should talk to the resident. The DON stated after the resident's RP called the facility on 05/02/2024, the facility did not conduct an investigation because they had residents that did not like staff, and they tried to accommodate changes. According to the DON, any suspicion of abuse must be investigated. The DON stated the Administrator was ultimately responsible for abuse allegations. (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/2024 at 2:31 PM, CNA #1 stated Resident #44 became upset during perineal care and stated the CNA hurt them. According to CNA #1, the resident was raw in their perineal area and stated their perineal area hurt. CNA #1 stated she left the resident's room and notified LPN #4. Per CNA #1, she was not assigned to care for the resident for at least one week after the resident reported they were hurt during perineal care. CNA #1 stated no one at the facility interviewed her regarding the incident. During an interview on 05/08/2024 at 7:02 PM, LPN #7 stated about a week or two ago, Resident #44 mentioned to her that a dayshift CNA was rough with them. According to LPN #7, she passed the information on to the dayshift nurse and told the dayshift nurse the CNA should not be assigned to care for the resident.

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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. 35314 Based on interviews, record review, and facility policy review, the facility failed to investigate an allegation of potential abuse for 1 (Resident #44) of 1 sampled resident reviewed for abuse. Findings included: A facility policy titled, Patient Protection and Response Policy for Allegations/Incident of Abuse, Neglect, Misappropriation of Property and Exploitation, revised on 02/01/2023, revealed, Any patient event that is reported to any partner by patient, family, other partner or any other person will be considered an allegation of either abuse, neglect, misappropriation of patient property of exploitation if it meets any of the following criteria: 1. Any allegation (or) indication of possible willful infliction of injury to include unexplained bruising. 2. Unreasonable confinement, to include unwanted restriction of access to all patient areas of the building. 3. Any patient or family complaint of physical or verbal harm, pain or mental anguish resulting from the actions of others. Per the policy, A. Internal Investigation Policy 1. Policy All events reported as possible abuse, neglect, or misappropriation of patient property will be investigated to determine whether the alleged abuse, neglect, misappropriation of patient property or exploitation did or did not take place. The Administrator or Director of Nurses will determine the direction of the investigation once notified of alleged incident. A Resident Face Sheet indicated the facility admitted Resident #44 on 05/19/2022, with diagnoses to include congestive heart failure, protein-calorie malnutrition, left shoulder arthritis, age-related osteoporosis, and osteoarthritis. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/16/2024, revealed Resident #44 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. The MDS revealed Resident #44 was dependent on staff for toileting hygiene, showering/bathing, and upper and lower body dressing; and required substantial/maximal assistance with personal hygiene and rolling left and right. Per the MDS, Resident #44 was always incontinent of bowel and bladder. Resident #44's Care Plan, with a start date of 05/20/2022, revealed the resident had a self-care deficit related to congestive heart failure, adult failure to thrive, tremors, and incontinence. A handwritten note on a Physician's Orders form, written by Licensed Practical Nurse (LPN) #4 and dated 04/24/2024, revealed as Certified Nurse Aide (CNA) #1 provided Resident #44 a bath, the resident stated the CNA hurt them by cleaning them roughly. According to the handwritten note, a nurse spoke with the resident on 04/24/2024 to explain good perineal care. A handwritten note on a Physician's Orders form, written by LPN #4 and dated 05/02/2024, revealed Resident #44's Responsible Party (RP) called the facility and stated they did not want CNA #1 to go into Resident #44's room again due to concerns with home the CNA cleaned the resident. (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 05/06/2024 at 10:20 AM, Resident #44 stated last month, CNA #1 shoved them back and forth violently. Resident #44 stated they complained enough about the CNA and now the CNA had not entered their room again. During an interview on 05/07/2024 at 8:43 AM, the Social Worker, who also served as the Abuse Coordinator, stated she was not aware of Resident #44's perineal care concerns or that the resident's RP called the facility about a CNA until 05/06/2024. The Social Worker stated the facility did not investigate the resident's concerns. The Social Worker stated had she been aware, she would have interviewed the resident. During an interview on 05/07/2024 at 1:11 PM, Resident #44's RP stated Resident #44 contacted them regarding a CNA that twisted their legs and hit their head against the bed. The RP stated Resident #44 did not want the CNA to care for them again. According to the RP, they did not inform the nurse of the resident's allegation. During an interview on 05/08/2024 at 11:04 AM, LPN #4 stated on 04/24/2024, CNA #1 came out of Resident #44's room and informed her that Resident #44 was upset with her. LPN #4 stated she went into Resident #44's room and the resident told her that CNA #1 had been rough. LPN #4 stated she did not notify anyone about Resident #44's statement and there was no documented evidence of any further action that was taken to investigate the resident's concerns. According to LPN #4, she spoke with Resident #44's RP on 05/02/2024 and the RP stated they did not want CNA #1 to provide care to Resident #44 anymore. LPN #4 stated she notified the Director of Nursing (DON) on 05/02/2024 of the RP's wishes for CNA #1 not to work with the resident anymore. During an interview on 05/08/2024 at 12:54 PM, the DON stated after Resident #44's RP called the facility, LPN #4 notified her that the RP did not want CNA #1 to provide care to Resident #44 anymore. The DON stated LPN #4 only informed her there were issues with perineal care, which the DON stated she did not feel was abusive. However, the DON stated, if staff were rough, the facility should talk to the resident. The DON stated after the resident's RP called the facility on 05/02/2024, the facility did not conduct an investigation because they had residents that did not like staff, and they tried to accommodate changes. According to the DON, any suspicion of abuse must be investigated. The DON stated the Administrator was ultimately responsible for abuse allegations. During an interview on 05/08/2024 at 2:31 PM, CNA #1 stated Resident #44 became upset during perineal care and stated the CNA hurt them. According to CNA #1, the resident was raw in their perineal area and stated their perineal area hurt. CNA #1 stated she left the resident's room and notified LPN #4. Per CNA #1, she was not assigned to care for the resident for at least one week after the resident reported they were hurt during perineal care. CNA #1 stated no one at the facility interviewed her regarding the incident. During an interview on 05/09/2024 at 9:46 AM, the Administrator stated the facility should have completed an investigation into Resident #44's reported allegations of a CNA being rough to determine what happened and to ensure a resident was not harmed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 28193 Based on observations, interviews, record reviews, and facility policy reviews, the facility failed to follow proper infection control practices during tracheostomy care for 1 (Resident #62) of 4 sampled residents reviewed for respiratory care. The facility further failed to store oxygen tubing and a nasal cannula when not in use in accordance with the facility policy for 1 (Resident #29) of 4 sampled residents reviewed for respiratory care. Findings included: 1. A facility policy titled, Tracheostomy Care, revised in July 2014, revealed, The inner cannula of the double-cannula tracheostomy tube may be disposable or non-disposable. The disposable tube is changed daily and as needed to maintain a patent airway. The non-disposable tube is cleaned when necessary but a minimum of one time per shift or every 12 hours. Both procedures are sterile and are performed by the RN [Registered Nurse] or LPN [Licensed Practical Nurse]. The policy revealed, Equipment: 1. Sterile suction kit 2. Trach [tracheostomy] care kit containing the following sterile equipment: two solution containers, hemostat or forceps, gloves, cotton-tipped applicators, brush and/or pipe cleaners, 4x4 sponges, towel, and tracheostomy dressing. 3. Sterile normal saline 4. Water-proof trash bag 5. If disposable, a same size sterile inner cannula According to the policy, 4. Put a sterile glove on the dominant hand and a nonsterile glove on the nondominant hand. The nonsterile hand will control the suction port or Y connector. 5. Using the sterile hand, prepare a sterile filed with the trach care kit. A Face Sheet revealed the facility admitted Resident #62 on 04/18/2022, with diagnoses to include paralytic syndrome following cerebral infarction, encounter for attention to tracheostomy and chronic respiratory failure with hypoxia. An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2024, revealed Resident #62 had a Staff Assessment for Mental Status (SAMS), which indicated the resident has severely impaired cognitive skills for daily decision making. The MDS indicated the resident was dependent on staff for most activities of daily living (ADLs). The MDS indicated, Resident #62 required oxygen therapy, suctioning, and tracheostomy care. Resident #62's Care Plan, with a problem start date of 04/19/2022 and edited on 04/27/2024, revealed the resident was at risk for respiratory complications related to paralytic syndrome, locked in state, tracheostomy, and chronic respiratory status. Interventions directed the staff to provided tracheostomy care as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/08/2024 at 9:42 AM, the surveyor observed Respiratory Therapist (RT) #12 provide tracheostomy care for Resident #62, in the presence of the Infection Preventionist (IP). There was a table prepared with a barrier and unopened supplies that were to be used during the tracheostomy care. RT #12 wore nonsterile gloves to open and handle sterile items that included a humidifier, inner cannula, and the tracheostomy kit, which included two cotton-tip applicators and split gauze. RT #12 handled all these items then placed sterile gloves on top of gloves she already had on. RT #12 proceeded to remove the dirty humidifier and placed it on the barrier next to the clean humidifier. During the provision of the tracheostomy care, RT #12 used the same gloved right hand to perform all tasks, to include the removal of soiled items and placement of clean items. After application of soaked split gauze, with her same gloved right hand, RT #12 removed the old inner cannula, discarded it, applied a new inner cannula, and cleaned around the stoma of the resident's tracheostomy. During an interview on 05/08/2024 at 10:01 AM, RT #12 stated she only washed her hands before and after the resident's tracheostomy care and not in between clean and dirty tasks. RT #12 stated it was not the facility policy to put sterile gloves on top of nonsterile gloves. During an interview on 05/08/2024 at 10:07 AM, the Director of Nursing (DON) stated it was not the policy of the facility to double glove for any procedure. The DON stated the staff's hands should be washed prior to application of gloves, after removal of soiled items and gloves, and when tracheostomy care was completed. The DON stated she expected nurses and respiratory therapists to follow the facility policy and always maintain infection control practices when tracheostomy care was performed. During an interview on 05/08/2024 at 10:25 AM, the IP stated staff were never to double glove and there were several infection control breaches during the tracheostomy care provided by RT #12 to Resident #62. The IP stated RT #12 failed to wash her hands between clean and dirty tasks. The IP explained that she was rather shocked by the way the tracheostomy care was performed by RT#12. 2. A facility policy titled, 306 Respiratory, updated in April 2024, revealed, 1. Equipment associated with machines such as oxygen, nebulizers, IPPB [intermittent positive pressure breathing] machines and suction machines are not shared among patients. 2. Respiratory equipment is dated when placed at bedside and replaced on a schedule. The policy indicated, 3. Respiratory equipment (i.e. [id est, Latin for that is], nasal cannula, aerosols, etc. [et cetera, and so forth]) at bedside will be covered with a plastic bag when not in use. A Face Sheet revealed the facility admitted Resident #29 on 05/29/2020, with diagnoses to include Alzheimer's disease, hypertension, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/07/2024, revealed Resident #29 had had a Staff Assessment for Mental Status (SAMS), which indicated the resident has severely impaired cognitive skills for daily decision making. The MDS indicated the resident required the use of oxygen therapy. Resident #29's Care Plan, with a problem start date of 05/21/2021, revealed the resident was at risk for complications related to hypertension and oxygen dependency. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/06/2024 at 10:06 AM, the surveyor observed Resident #29 lying in bed and a nasal cannula was draped over the top of the resident's geriatric chair uncovered, attached to an oxygen cylinder on the back of the geriatric chair. On 05/06/2024 at 10:44 AM, Certified Nurse Aide (CNA) #13 verified Resident #29's nasal cannula and oxygen tubing was uncovered and draped on the geriatric chair. On 05/07/2024 at 12:10 PM, the surveyor observed and Licensed Practical Nurse (LPN) #14 confirmed that Resident #29's nasal cannula was uncovered and draped over the back of the geriatric chair. During an interview on 05/08/2024 at 10:07 AM, the Director of Nursing stated she expected staff to store respiratory tubing covered.