

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445017	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/14/2026
NAME OF PROVIDER OR SUPPLIER Asbury Place at Maryville		STREET ADDRESS, CITY, STATE, ZIP CODE 936 Epworth Road Maryville, TN 37804	
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 - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review and interview, the facility failed to administer comfort medications to 1 resident (Resident #118) of 4 residents sampled for hospice service. The facility failure resulted when the facility failed to transcribe the hospice physician's orders timely into the medical record and Licensed Practical Nurse (LPN) T failed to administer the medications as prescribed on the morning of [DATE] when Resident #118 was actively dying. The facility neglected to provide goods and services necessary to avoid physical harm, pain, mental anguish, or emotional distress when they failed to administer medications as ordered by the hospice physician which resulted in actual HARM to Resident #118. The findings include: Review of the undated facility policy titled, Guidelines for Pain Management, undated, revealed .It is the intent of the facility to promote resident .comfort .and preserve dignity in an ongoing effort to promote .quality for their lives .one aspect .is to maintain .effective pain management .Methods to Achieve Goals of Pain Management .Promptly and accurately recognizing and assessing pain .using pain medications .Any orders received from the physician to include medications .will be implemented and carried out .The resident will be placed on enhanced monitoring .Pain will be managed in a timely manner to include pain that is new and of a recent onset .Any orders implemented .will be carried out .Nursing observation is critical to pain assessment .especially in non-verbal residents .these include, but are not limited to .facial expressions .body movements .crying out or moaning .rigidity .sweating .increased heart rate .Any time a nurse is contacted regarding a prn [as needed] medication request .the time the nurse was contacted will be documented in the resident's medical record . Review of the undated facility policy titled, Medication Administration, revealed .To ensure resident medications are administered in a timely manner .The reason for not administering .medication will be documented . Review of the Hospice Care Plans and Interdisciplinary Team Notes for Resident #118 dated [DATE] (resident on hospice services prior to admission to the facility) revealed the resident received hospice services with diagnoses including Neurocognitive Disorder with Lewy Bodies, Unspecified Dementia, and Do Not Resuscitate Status. Review of the medical record revealed Resident #118 was admitted to the facility on [DATE] with diagnoses including Neurocognitive Disorder with Lewy Bodies (a degenerative neurological disorder), Encounter for Palliative Care, Anxiety Disorder, and Adult Failure to Thrive. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #118 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact and required moderate to maximal assistance with activities of daily living. Review of the Hospice Client Coordination Notes and Corresponding Physician Orders for Resident #118 dated [DATE] (time of Hospice Nurse arrival to the facility was approximately 10:30 AM), revealed .an expected very short life expectancy of days to one week .near death .utilizes non-verbal indicators of pain .labored tachypnea [labored rapid shallow breathing] 32 breaths per minute [normal respirations</p> <p>(continued on next page)</p>		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>12-20] .Pt [patient-Resident #118] is active [actively dying] .No PO [oral] intake in 2 days .HR [heart rate] tachycardic [elevated] and irregular at 132 BPM [beats per minute] [normal heart rate is 60 to 100 beats per minute] .Temp [temperature] 98.9 .skin is warm, clammy to touch .Visits increased to daily .Morphine Sulfate [a narcotic to relieve severe pain] .Ativan [an anti-anxiety medication used to reduce air hunger and anxiety] .Q [every] 4H [hours] .Morphine Q2H .PRN [as needed] .Hyoscyamine [A medication to reduce secretions] Q4H .DTR [Daughter] present for visit .EOL [end of life] education provided .Report given to facility [LPN T] .POC [plan of care] reviewed .instructed [LPN T] to call [hospice provider] with any questions or concerns .? Review of a Hospice Facsimile (Fax) transmission record dated [DATE], marked urgent revealed the written physician orders for Resident #118 were successfully transmitted to the facility and the facility's pharmacy provider at 11:26 AM on [DATE].? Review of the Nurse's Note for Resident #118 dated [DATE] at 2:02 PM, written by LPN T revealed .This nurse [LPN T] went in this morning to check on resident [Resident #118] and checked vital signs .HR .147 .Respirations .32 .Resident has not been eating or drinking .Hospice nurse contacted and had come up here [to the facility] and evaluated resident .Hospice nurse states resident appears to be actively dying .Daughter in room with resident . ?Continued review of the nurse's note showed no references to medication orders or administration of comfort medications to Resident #118.? Review of the Nurse's Note for Resident #118 dated [DATE] at 3:56 PM, written by LPN T revealed .CNA [Certified Nurse Aide] came into nurses' station and informed this nurse [LPN T] she [CNA] thinks the patient [Resident #118] is gone [expired]. This nurse [LPN T] went in to check on the resident [Resident #118] and found no vital signs present .Family at bedside .Hospice notified and nurse [Hospice Nurse] is on the way [to the facility] to pronounce [death] . Review of the Nurse's Note for Resident #118 revealed there was no other documentation related to ongoing monitoring of the resident's change in condition after it was determined by the hospice nurse Resident #118 was actively dying at approximately 11:00 AM on [DATE]. Review of the Medication Administration Record (MAR) for Resident #118 dated [DATE]-[DATE], revealed the hospice orders for Morphine, Lorazepam, and Hyoscyamine, transmitted to the facility at 11:26 AM on [DATE] were not administered to the resident as ordered. During a telephone interview on [DATE] at 7:30 PM, LPN T stated she was previously employed at the facility as a contracted travel nurse in 2025 and worked day shift (7:00 AM to 7:00 PM). LPN T stated she recalled Resident #118, but due to the passage of time could not remember many details about the resident. LPN T stated she contacted the hospice nurse on the morning of [DATE] of Resident #118's change in condition but was unable to recall any additional details. During interview on [DATE] at 8:20 AM, Resident #118's daughter stated on the morning of [DATE] between 8:30 AM and 9:30 AM she observed her mother (Resident #118) with altered mental status, faint moaning, rapid shallow breaths, and appeared to be in distress. Resident #118's daughter also stated the resident's skin was pale, moist to touch and abnormally warm. Resident #118's daughter searched for facility staff on the unit and located LPN T at the nurse's station and asked LPN T if she had assessed the resident. Resident #118's daughter stated she contacted the hospice nurse by text message at 9:56 AM to report the resident's change in condition. Resident #118's daughter stated the hospice nurse arrived at the facility around 10:30 AM (after she sent report of 0017 0142the residents change in condition) to assess the resident and informed the daughter the resident was actively dying. Resident #118's daughter waited for the arrival of a family friend prior to leaving the facility to retrieve her children around 12:30 PM and to inform Resident #118's family the resident was actively dying. The family friend remained at the bedside until the daughter returned to the facility around 2:00 PM. The family friend informed Resident #118's daughter nursing staff had not assessed the resident or administered any</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>medication during her absence. Resident #118's daughter stated she went to find LPN T and questioned why Morphine or other medications had not been administered to the resident. Resident #118's daughter stated LPN T informed the medication was awaiting delivery from the facility's pharmacy provider. Resident #118's daughter contacted the hospice nurse to inquire why medications were not available. The hospice nurse informed Resident #118's daughter, medications could be retrieved from the facility's emergency medication stock and administered to the resident. Resident #118's daughter requested LPN T to administer the medications as ordered by hospice and received no response from the nurse. Resident #118 continued to be short of breath, clammy, with facial grimace, head tremors, pale, and appeared to be in pain. Resident #118's daughter stated LPN T did not administer comfort medications to the resident despite her repeated requests. When asked how she felt Resident #118's daughter became tearful, was deeply saddened, and angered by the experience. Resident #118's daughter stated her mother suffered unnecessarily as she passed away. During medical record review and interview on [DATE] at 9:30 AM, the Director of Nursing (DON) confirmed there was no evidence medications ordered on [DATE] by the hospice physician were administered to Resident #118 by LPN T. During a telephone interview on [DATE] at 11:17 AM, the former DON reported she left employment at the facility in 2/2025. The former DON stated the facility-maintained emergency stocks of medications to include Morphine, Lorazepam, and Hyoscyamine. These medications could have been removed from the emergency stock and immediately administered to Resident #118 in accordance with hospice provider orders. During a telephone interview on [DATE] at 7:54 PM, the family friend of Resident #118 who remained at the resident's bedside on [DATE] stated she remained at the bedside for approximately 1.5 hours but could not remember exact times. During the family friend's time at the bedside, she did not witness nursing staff assess or administer medications to Resident #118. During a telephone interview on [DATE] at 10:28 AM, the Hospice Nurse recalled Resident #118's case in detail. The Hospice Nurse stated she was notified by Resident #118's daughter by text message on the morning of [DATE] of the resident's decline. The Hospice Nurse stated she had not been notified by staff at the facility of Resident 118's decline. The Hospice Nurse stated she assessed Resident #118 and determined the resident was in pain, with elevated vital signs, and was actively dying. The Hospice Nurse contacted the Hospice Physician immediately, obtained orders for comfort medications and informed the family at bedside of Resident #118's condition. The Hospice Nurse stated she met with LPN T and advised the LPN Resident #118 was actively dying, required PRN medications for comfort, and specifically instructed LPN T on the comfort medication regimen. The Hospice Nurse provided verbal orders to LPN T and advised the LPN to obtain comfort medications from the facility stock and administer the medications immediately. Further interview revealed after Resident #118's death, representatives of the hospice service met with the facility former DON, former social worker, and former Administrator and expressed their concerns LPN T had not followed hospice orders and did not assess Resident #118 between the initial hospice visit on the morning of [DATE] at approximately 10:30 AM and the resident's death at approximately 3:56 PM. The Hospice Nurse confirmed failure to administer comfort medications to Resident #118 caused harm to the resident and in her professional judgement caused the resident to .die in agony .</p>		