

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/15/2026
NAME OF PROVIDER OR SUPPLIER  Buchanan Place		STREET ADDRESS, CITY, STATE, ZIP CODE  902 Buchanan Rd New Tazewell, TN 37825	
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)		
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, facility investigation documentation review, medical record review, observations, and interviews, the facility failed to protect the resident's right to be free from physical abuse by another resident for 1 resident (Resident #15) of 22 residents reviewed for abuse. Resident #17 struck Resident #15 on 4/20/2025 and again on 5/7/2025. The findings include: Review of the facility policy titled, Freedom from Abuse and Neglect Policy, not dated, revealed .each resident has the right to be free from abuse. Abuse includes, verbal, mental, physical . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Essential Hypertension, and Type 2 Diabetes Mellitus. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated resident is cognitively intact. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Aphasia, Cognitive Communication Deficit, Chronic Kidney Disease, and non-Hodgkin lymphoma. Review of a quarterly MDS assessment dated [DATE], revealed Resident #17 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Review of a Nursing Progress Note for Resident #17 dated 4/20/2025, revealed .called to room .observed CNA (certified nursing assistant) removing resident (Resident #17) from room .Resident (Resident #15) stated she hit me three times in the left arm .This nurse .called Abuse Coordinator . Review of a Nursing Progress Note dated 4/20/2025, revealed .called on call physician .seen both residents (Resident #15 and #17) via video call. New order for Resident (Resident #17) to be 1 on 1 x 24 hours . Review of a skin assessment for Resident #15 dated 4/20/2025, revealed .slight redness above ac (antecubital) during assessment . Review of the comprehensive Care Plan for Resident #15 revised 4/21/2025, revealed, .stop sign to door-assist resident as needed to keep stop sign on door in place . Review of a Nursing Progress Note for Resident #17 dated 5/7/2025, revealed .Nurse .reported that she was at the nursing station when heard yelling on .hall .she observed (Resident #17) exiting another resident's room. Residents were immediately separated and assessed .skin assessments completed with no issues noted .resident placed one on one with staff while up in chair . Review of the facility investigation dated 5/7/2025, at 4:35 PM revealed .nurse reported she was at nurse's station when she heard yelling on B hall. As she was going down B hall, she observed another resident exiting [Resident #15] room. When asked what happened, [Resident #15] said she asked the other resident [Resident #17] to leave, and she began hitting her .residents separated immediately. Skin assessment completed .redness noted to left upper breast and left index finger knuckle. No open areas or swelling noted. Resident denies pain .No injuries noted at time of incident . Review of a skin assessment for Resident #15 dated 5/7/2025, at 8:54 PM revealed no areas of concern documented. Review of an .Employee Warning Form . dated 5/8/2025, revealed employee violation .did not attach stop sign across doorway after returning the resident from an appointment .To avoid further disciplinary action, employee should: Review cardex to ensure that we are following the care plans for each resident . Review of a facility QAPI (quality assurance and performance improvement) meeting dated 5/8/2025, revealed (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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>agenda .abuse, resident rights, cardex review-following care plans .stop sign monitoring daily 5x (times) /week for 4 weeks . Review of a social services progress note dated 5/8/2025, revealed SW [social worker] spoke with resident [Resident #17] spouse and son .about room change .was agreeable . During an interview with the facility Scheduler on 4/13/2026 at 2:16PM, the Scheduler stated the stop sign was an intervention put in place after the first incident between [Resident #15 and Resident #17]. Continued interview revealed the Scheduler did receive the written education after not re-attaching the stop sign after bringing back [Resident #15] from an appointment. During a phone interview with Licensed Practical Nurse (LPN) D on 4/13/2026 at 4:37 PM, LPN D stated he completed the skin assessment on Resident #15 in the evening of 5/7/2025. Continued interview revealed Resident #15 had no signs of injury or bruising after the resident-to-resident contact as the 5/7/2025 skin assessment stated. During an observation on 4/14/2026 at 8:24 AM, revealed the stop sign outside Resident #15 room not in place. Continued observation revealed no staff observed in sight of room with Resident #15 sitting on side of bed. During an interview with Resident #15 on 4/14/2026 at 8:25 AM, the Resident stated Resident #17 did come into her room on two separate occasions when she was located across the hallway and struck her. Continued interview revealed Resident #15 stated .she didn't hurt me .no other concerns since .she's not the same person now . Further interview revealed Resident #15 stated .they [facility staff] don't keep the stop sign up much now . During an observation and interview with LPN A on 4/14/2026 at 8:27 AM, the LPN stated the stop sign was supposed to be in place .that's my fault . Continued interview revealed the LPN forgot to put the stop sign back up after exiting Resident #15's room. During an interview and medical record review on 4/14/2026 at 8:40 AM, the Director of Nursing (DON) stated Residents #15 and #17 had no further resident to resident altercations or any lasting effects with facility follow up by social services. Continued interview and medical record review confirmed the DON expected the stop sign to be in place for Resident #15. During an interview on 4/15/2026 at 9:15 AM, the DON confirmed physical contact did take place between Resident #15 and Resident #17, when Resident #17 struck Resident #15 on 4/20/2025 and 5/7/2025, and neither resident sustained any injuries.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on facility policy review, medical record review, and interviews, the facility failed to implement the comprehensive care plan for 1 resident (Resident #15) for 22 residents reviewed for care plans. The findings include: Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed .A comprehensive, person- centered care plan that includes measurable objectives .to meet the resident's physical, psychosocial and functional needs .the care plan interventions are derived from a thorough analysis of the information gathered . Review of the medical record revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including Chronic Kidney Disease, Essential Hypertension, and Type 2 Diabetes Mellitus. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #15 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated resident is cognitively intact. Review of the comprehensive Care Plan for Resident #15 revised 4/21/2025, revealed, .stop sign to door-assist resident as needed to keep stop sign on door in place . During an observation on 4/14/2026 at 8:24 AM, revealed the stop sign outside Resident #15 room not in place. Continued observation revealed no staff observed in sight of room with Resident #15 sitting on side of bed. During an interview with Resident #15 on 4/14/2026 at 8:25 AM, the Resident stated .they [facility staff] don't keep the stop sign up much now . During an observation and interview with LPN A on 4/14/2026 at 8:27 AM, the LPN stated the stop sign was supposed to be in place .that's my fault . Continued interview revealed the LPN forgot to put the stop sign back up after exiting Resident #15's room. During an interview and medical record review on 4/14/2026 at 8:40 AM, the Director of Nursing (DON) confirmed Resident #15's care plan intervention was not followed. Continued interview revealed the DON stated she expected the stop sign to be in place for Resident #15's door.</p>		