STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchardview Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to notify the physician of abnormal laboratory (lab) results for 1 resident (Resident #19) of 3 residents reviewed. The findings include: Review of the facility's undated policy titled, Notification of Changes, revealed .promptly informs .residents' physician .when there is a change requiring notification .significant change in the residents' condition .clinical complications . Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Stroke, Anxiety, Depression, and Diabetes. Review of lab results for Resident #19 dated 4/24/2026, revealed .Glucose 822 (CH) [Critical High] .reference range 74-109 . Continued review revealed there was no documentation the Physician or Nurse Practitioner (NP) were notified of the laboratory results. Continued review revealed it was unclear the exact time the lab company had notified the facility on 4/24/2026 of the critical high-level result for Resident #19. Review of a physician note for Resident #19 dated 4/25/2026, revealed .Patient [Resident #19] seen at request of nursing for follow-up for increased behaviors .Nursing was asked if patient had any recent labs and reported he did have labs with a high glucose (blood sugar) but was not sure if it had been called to anyone [provider] .Review of lab show that patient had a result of a critical glucose of 822 at 0300 [3: 00 AM] today .Nursing was asked if they had rechecked this reading and they said No .Nursing was asked to check patients glucose and glucometer was reading high [high glucometer reading are typically 600 or above] .Nursing was advised to give 10 units of lispro (medication to lower blood sugar) and recheck glucose in 1 hour and contact provider with the results .Orders were also given for patient to receive normal saline 500 ml [millimeter] bolus. Orders for CBC [Complete Blood Count], CMP [Comprehensive Metabolic Panel] .Nursing to call provider back and glucose was still reading high after normal saline bolus, 10 units lispro .Orders were given to give another 10 units of lispro and an additional 500 ml bolus of normal saline .Nursing to call provider for call and recheck in an hour .Nursing reported patient .sending him to hospital . During a telephone interview on 6/10/2026 at 9:13 AM, Nurse Practitioner (NP) A stated she could not remember Resident #19 and did not have access to his medical records at the time of the interview. NP A further stated there was a delay in notification to the provider of the critical high glucose lab value of Resident #19. During a telephone interview on 6/10/2026 at 10:00 AM, Licensed Nurse Practitioner (LPN) B stated on 4/25/2026 at the beginning of the day shift, the LPN entered into the electronic lab system on the computer and checked to see if any labs had resulted. LPN B stated Resident #19 had a critical blood glucose of 822 (normal range 70-100) and reported it to NP A on 4/25/2026 immediately after viewing the result. LPN B further stated she gave Resident #19 extra doses of insulin and a bolus of fluids as ordered. LPN B further stated Resident #19 was transported to the emergency room for further evaluation. During an interview on 6/10/2026 at 10:45 AM, the Director of Nursing (DON) stated it was the facility's expectation for nursing staff to report any critical lab results to the provider immediately and there had been a delay in reporting the critical high lab value for Resident #19 to the provider. During an interview on 6/10/2026 at 11:00 AM, NP C stated she had not been notified by the facility nursing (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchardview Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff of Resident #19's critical high lab results on 4/24/2026. During an interview on 6/10/2026 at 11:57 AM, the Medical Director (MD) stated he had not been informed of the critical high glucose level for Resident #19 until he was notified by NP A on 4/25/2026 (1 day after receipt of lab value, exact timeframe was unknown). The MD stated Resident #19 had routinely had high glucose level readings and was being treated by the providers. The MD further stated the resident did not have an adverse outcome or harm from the delay in the notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchardview Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observations, and interviews, the facility failed to ensure insulin medications were labeled appropriately to include an open date for 2 residents (Resident #62 and Resident #67) of 7 residents reviewed for insulin storage. The findings include: Review of the facility's undated policy titled, Labeled and Storage, revealed .Guidelines .all medications .used in the facility .will be labeled in accordance with current .federal regulations .the date .initial opened or accessed .should be discarded within 28 days . Review of the medical record revealed Resident #62 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus (DM), Hypertension, and Chronic Obstructive Pulmonary Disease. Review of a Physician's Order for Resident #62 dated 1/27/2026, revealed .Insulin Glargine [long acting insulin medication used to lower blood glucose levels] Subcutaneous Solution .100 Unit/ML [milliliter] .Inject 12u [units] Subcutaneous .at Bedtime for Diabetes . Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including DM, Hypertension, and Hyperlipidemia. Review of a Physician's Order for Resident #67 dated 3/17/2026, revealed .Semglee Subcutaneous Solution [long acting insulin medication used to lower blood glucose levels] .100 Unit/ML .Inject 44 unit subcutaneous .at Bedtime .for DM . During an observation of medication cart 200-top cart on 6/9/2026 at 7:30AM, revealed an opened Glargine Subcutaneous Solution 100 Unit/ML insulin pen for Resident #62. The opened insulin pen was undated and available for resident use. Further observation revealed an opened Semglee Subcutaneous Solution 100 Unit/ML insulin pen for Resident #67, also undated and available for resident use. During an interview on 6/10/2026 at 8:00AM, Licensed Practical Nurse (LPN) E confirmed the insulin pens were not dated when opened for Resident #62 and Resident #67 and were stored and available for resident use. During an interview on 6/10/2026 at 2:14PM, the Director of Nursing confirmed 2 insulin pens were opened and undated in the medication cart and available for resident use for Resident #62 and Resident #67.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchardview Post-Acute and Rehabilitation Center	2035 E Stonebrook Place Kingsport, TN 37660

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 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 facility policy review, medical record review, observations, and interviews, the facility staff failed to perform appropriate hand hygiene when serving residents' meal service for 2 residents (Residents #18 and #22) on 1 of 2 units observed for meal tray distribution. The Findings include: Review of the facility's undated policy titled, Hand Hygiene guidelines, revealed .All staff will perform proper hand hygiene .residents .before eating . Review of a facility's undated document titled, Tidy Hands Program, revealed .assist with residents handwashing .before meals . Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Dementia, Dysphagia, and Need for Assistance with Personal Care. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #18 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed the resident required set up or clean-up assistance with eating. Review of a comprehensive care plan dated 5/26/2026, revealed Resident #18 had a .ADL [Activities of Daily Living] self-care deficit r/t [related to] weakness and dementia .Eating .able to feed self after set up . During an observation on 6/8/2026 at 12:33 PM, Certified Nurse Assistant (CNA) D delivered the meal service to Resident #18. CNA D set up meal for Resident #18 and failed to offer hand hygiene to the resident prior to exiting the room. Review of the medical record revealed Resident #22 was admitted to the facility on [DATE] with diagnoses including Diabetes, Need for Assistance with Personal Care, and Depression. Review of the quarterly MDS assessment dated [DATE], revealed Resident #22 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident required set up or clean-up assistance with ADL's. Review of a comprehensive care plan for Resident #22 dated 8/21/2023, revealed .ADL .staff assistance .assist with meal set up . During an observation on 6/8/2026 at 12:45 PM, CNA D delivered the meal service to Resident #22. CNA D set up meal for Resident #22 and failed to offer hand hygiene to the resident prior to exiting the room. During an interview on 6/8/2026 at 12:50 PM, CNA D confirmed she had not offered hand hygiene while passing the meal service to Residents #18 and #22. During an interview on 6/9/2026 at 1:48 PM, the Director of Nursing stated it was the facility's expectations hand hygiene was to be offered to residents prior to meals. The DON confirmed the facility failed to follow infection control policies when staff did not offer hand hygiene to Resident #18 and #22.