STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445207	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wexford House	2421 John B Dennis Highway 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 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 review of facility policy, medical record review, review of facility investigation and interview, the facility failed to report an allegation of abuse to the State Survey Agency for 1 resident (Resident #1) of 5 residents reviewed for abuse. The findings include: Review of the facility's undated policy titled Abuse, Neglect, and Exploitation revealed .it is the policy of this facility to provide .procedures that prohibit and prevent abuse . Abuse .includes .mental abuse including abuse facilitated or enabled through the use of technology .The facility will designate an Abuse Coordinator in the facility who is responsible for reporting allegations or suspected abuse .to the state survey agency .The facility Abuse Coordinator will be the Administrator . Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Lumbar Spina Bifida, Neuromuscular Dysfunction of Bladder, and Artificial Opening of Urinary Tract, the resident discharged to a hospital on [DATE]. Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1's Brief Interview of Mental Status (BIMS) score was 14 indicating the resident was cognitively intact. The resident required assistance of one or more persons with activities of daily living (ADL's).Review of the facility's investigation revealed several statements dated 10/23/2025 revealed Certified Nurse Assistants (CNA's) B, C, D, and License Practical Nurse (LPN) A stated CNA E had photos of Resident #1's back/wounds on her phone, and she sent the photos to the ombudsman. A statement signed by Resident #1 revealed the resident did not give permission to CNA E to take any photos of her. Another statement signed by the Director of Nursing (DON) revealed Resident #1 stated to her .she took pictures without me knowing . Another statement by the Administrator revealed CNA E denied she had photos of the resident and .stated she did not ever use her phone in the facility . None of the statements revealed anyone saw any photos of the resident on CNA E's or any other employee's phone.During an interview on 11/12/2025 at 8:40 AM, the Administrator stated .normally I do report to the state but this one I did not . During an interview by phone on 11/13/2025 at 10:15 AM, the Ombudsman stated .I have not received any pictures, and I have not talked to CNA E or anybody else about [Resident #1] .

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