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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445242	A. Building B. Wing	07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greystone Health Care Center	181 Dunlap Road Blountville, TN 37617

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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50216 Based on facility policy review, medical record review, police report review, facility investigation review, and interview the facility failed to protect the residents' right to be free from sexual abuse and physical abuse by another resident for 4 of 14 (Resident #11, #17, #18, and #5) sampled residents reviewed for abuse. On 6/25/2024, Resident #9 was observed with his hand on Resident #11's pelvic region and Resident #11 was observed shaking his head no. On 11/26/2023, Resident #18 grabbed Resident #17's arm resulting in a scratch to her finger and Resident #17 scratched Resident #18 on the face when Resident #18 entered Resident #17's room. On 3/15/2024, Resident #6 hit Resident #5 with a soda can in her chest area. The facility's failure to protect the residents' right to be free from abuse resulted in actual harm for Resident #11, #17, and #18. The findings include: Review of the facility policy titled, Abuse, Neglect and Exploitation, revised 1/10/2024, revealed .it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by . implementing written policies and procedures that prohibit and prevent abuse . 'Abuse' means the willful infliction .which can include .resident to resident altercations . 'Sexual Abuse' is non-consensual sexual contact of any type with a resident. 'Physical Abuse' includes, but is not limited to hitting . 1. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure, Hemiplegia following a Cerebral Infarction, and Epilepsy. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #11 scored 00 on the Brief Interview for Mental Status (BIMS) which indicated the resident had severe cognitive impairment. Resident #11 was nonverbal and dependent on staff for all activities of daily living. Review of the comprehensive care plan revised on 2/19/2024, revealed Resident #11 required staff assistance with all activities of daily living. Resident #11 also had impaired ability to communicate due to inability to speak with an intervention to .Pay attention to resident's body language and facial expressions . (continued on next page)

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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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a Psychiatric Periodic Evaluation for Resident #11 dated 6/26/2024, revealed .patient was the victim of another resident's inappropriate behavior .There has been no indication of increased anxiety, agitation, mood swings. No .psychosocial harm noted . Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Chronic Kidney Disease, Major Depressive Disorder, and Anxiety Disorder. Review of a Psychiatric Periodic Evaluation for Resident #9 dated 4/4/2024, revealed the resident's medications were changed from Sertraline to Paroxetine (antidepressants) . to get better impulse control coverage . Review of a Psychiatric Periodic Evaluation for Resident #9 dated 5/16/2024, revealed .He [Resident #9] reports his [Sertraline] is effective at this time . Review of an annual MDS assessment dated [DATE], revealed Resident #9 scored 15 on the BIMS which indicated the resident was cognitively intact. Resident #9 was dependent on staff for transfers into and out of a wheelchair and was able to move around in the wheelchair without assistance. Review of the Nurse's Notes dated 6/25/2024 at 6:30 PM, revealed Resident #9 was observed with his hand on Resident #11's pelvic region. Review of a Psychiatric Periodic Evaluation for Resident #9 dated 6/26/2024, revealed .thought to be touching another patient inappropriately. He vehemently denies this, states he was only 'straightening his blankets' Patient is currently on 1:1 [1 on 1] supervision with no further reports . Review of the comprehensive care plan for Resident #9 revised 7/19/2024, revealed verbal aggression and sexually inappropriate behaviors towards residents. Review of a local police report dated 6/25/2024, revealed the .Deputy .spoke with the nurse [Registered Nurse (RN) C]. RN C advised she needed a report completed for two residents involved in a sexual assault . [Respiratory Therapist (RT) A] saw [Resident #9] grope [Resident #11] .RT A stated she saw [Resident #9] pulling the blanket over himself and [Resident #11] and grope [Resident #11's] genital area. [Resident #11] was shaking his head no during the assault . Review of the undated witness statement from Hospitality Aide (HA) B revealed .on 6/25/2024 at 4:30 PM [HA B] saw [Resident #9] pulling down his [Resident #11] cover prior to the incident where Resident #9 was touching [Resident #11's] arm. [Resident #9] had his hand under [Resident #11's] arm and forearm .6 PM 6/25/2024 .[HA B] pointed out to [RT A] .[Resident #9] been .moving/adjusting [Resident #11's] cover. [Resident #9] was sliding his hand under his blanket .[RT A] responded and [Resident #9] stopped immediately . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a undated witness statement from HA A revealed .on 6/25/2024 [RT A] was standing at the nurse's station .[HA B] tapped me on the shoulder .told me to look and pointed towards [Resident #11]. [Resident #11] was in his wheelchair facing the nurse's station and [Resident #9] was facing the main entrance with their chairs touching. [Resident #9] had [Resident #11's] blanket pulled down and [Resident #11] was shaking his head no, while [Resident #9] was touching his pubic area. RT A started saying .hey hey stop .but before [RT A] could reach them [Resident #9] had already stopped and pulled the blanket up and patted [Resident #11] on the shoulder . During an interview on 7/29/2024 at 9:50 AM, Resident #9 stated he had been in an altercation with Resident #11. Resident #9 stated Resident #11 looked scared, Resident #9 reached over to hold Resident #11's hand and noticed Resident #11 was unable to use his hand. Resident #9 then reached across Resident #11's lap to hold Resident #11's other hand. Resident #9 stated someone witnessed him holding Resident #11's hand and thought he was trying to touch Resident #11's crotch area. Resident #9 stated after the incident the facility had a staff person follow him around for a few weeks. Resident #9 stated he understood touching Resident #11 was wrong. During an interview on 7/30/2024 at 12:45 PM, HA B stated on 6/25/2024 at approximately 5:50 PM, Resident #11 was sitting across from the nurse's desk, Resident #9 rolled up to Resident #11, and Resident #9 had his hand under the blanket covering Resident #11. HA B stated she tapped RT A to get her attention and pointed out the two residents. HA B stated Resident #11 had his hands and arms on the armrests of his wheelchair and Resident #9 had his hand on Resident #11's pubic area then the RT intervened and separated the two residents immediately. During an interview on 7/30/2024 at 1:11 PM, Registered Nurse (RN) C stated on 6/25/2024 at 5:50 PM, she was alerted by RT A Resident #9 had touched Resident #11's pubic area. The RN stated Resident #9 and Resident #11 were separated immediately. RN C stated the Administrator and Director of Nursing (DON) were notified of the incident. RN C stated when she interviewed Resident #9 the resident informed her he touched Resident #11's right arm, realized the resident could not move his right arm, and he reached for Resident #11's other arm. Resident #9 stated, he was trying to cover Resident #11 with the blanket. RN C stated she was unaware of any past incidents of sexually inappropriate behavior by Resident #9. During a telephone interview on 7/30/2024 at 1:18 PM, RT A stated HA B got her attention and pointed at Residents' #9 and #11. RT A was standing on the right side of the nurse's desk and noticed Resident #9 . caressing [Resident #11's] groin area . RT A stated she informed Resident #9 to stop (Resident #9 stopped), called for the nursing supervisor to come to the desk, and reported the incident between Resident #9 and #11. RT A stated she could clearly see Resident #11 had his arms on the armrests of his wheelchair, and Resident #9 was touching Resident #11's groin area. RT A stated Resident #9 was immediately placed on 1 to 1 supervision. During an interview on 7/30/2024 at 2:35 PM, the Administrator stated, the DON notified him of the incident which occurred between Resident #9 and Resident #11 which occurred on 6/25/2024. The Administrator stated RT A informed him she saw Resident #9 with his hand on Resident #11's pelvic area under the blanket. The Administrator stated Resident #9 was placed on 1 to 1 supervision immediately to protect the other residents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of facility documentation and interviews revealed Resident #11 was cognitively impaired and unable to speak. Resident #9 was cognitively intact, touched Resident #11's pubic area, and Resident #11 shook his head no wanting Resident #9 to stop. A reasonable person would not expect they would be harmed in a health care facility and would experience a negative psychosocial outcome to include fear, anxiety, anger, and/or humiliation. 49568 2. Review of the medical record revealed Resident #17 was admitted to the facility on [DATE] with diagnoses including Epilepsy, Chronic Kidney Disease, Hypertension, Chronic Pain Syndrome, and Generalized Anxiety Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #17 scored a 15 on the BIMS which indicated the resident was cognitively intact. Review of the Skin Assessment for Resident #17 dated 11/24/2023, revealed the resident had no abnormal skin areas. Review of an Event Note for Resident #17 dated 11/26/2023, revealed .at [4:00 PM] resident [Resident #17] was noted with skin tear to right fourth finger. When asked what happened she stated, .[Resident #18] came into my room [Resident #17's] and grabbed my hand and I wasn't putting up with it . Continued review revealed Resident #18 stated, .I don't know [when asked about the incident] .[Resident #18] placed on 1:1 observation with CNA [Certified Nursing Assistant] .The facility notified state[State Survey Agency] .residents families .MD [Medical Doctor] .and Psych NP [Psychiatric Nurse Practitioner] . Review of the Skin Assessment for Resident #17 dated 11/26/2023, revealed a skin tear on the right-hand 4th finger. Review of a NP's Progress Note for Resident #17 dated 11/28/2023, revealed .skin tear to right fourth finger . Steri-Strips [wound closure tape] .No signs of infection noted .calm .No pain . Review of a Psychiatric Evaluation for Resident #17 dated 11/28/2023, revealed .evaluation of mood and behaviors .resident recently involved in resident to resident altercation .another resident approached [Resident #17] .other resident [Resident #18] grabbed [Resident #17's] arm .[Resident #17] hit [Resident #18] and scratched her face .[Resident #17] stated the other resident [Resident #18] came into her room . [Resident #17] wanted her [Resident #18] to leave .[Resident #18] grabbed her [Resident #17] arm . Review of a Psychiatric Evaluation for Resident #17 dated 12/5/2023, revealed .no other behaviors reported . no other altercations reported . Review of the medical record revealed Resident #18 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Chronic Kidney Disease, Hypertension, Dementia, and Generalized Anxiety Disorder. Review of a comprehensive care plan dated 10/3/2023, revealed Resident #18 had .behaviors related to psychotic disorder .anxiety .delusions .thinking that she works here [at the facility] . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #18 scored 00 on the BIMS which indicated the resident had severe cognitive impairment. Review of a Skin Assessment for Resident #18 dated 11/20/2023, revealed the resident had no abnormal skin areas. Review of a Skin Assessment for Resident #18 dated 11/26/2023, revealed .left side of face scratch . Review of a NP Progress Note for Resident #18 dated 11/26/2023, revealed .[Resident#18] has an abrasion to the left side of her face .caused from an altercation with another resident [Resident #17] .does not appear to have any pain .confused .Apply [topical ointment] daily until healed . Review of a Psychiatric Evaluation for Resident #18 dated 11/28/2023, revealed .[Resident #18] was . involved in a resident-to-resident altercation .[Resident #18] grabbed another resident [Resident #17's] arm . [Resident #17] hit her [Resident #18] and scratched her [Resident #18] face .[Resident #18] has no recollection of this occurring .[Resident #18] was placed one-on-one sitter . Review of CNA I's Witness Statement dated 11/26/2023, revealed .found [Resident #18] standing in front of [Resident #17's] room .noticed large scratch on [Resident #18's] face .notified nurse . Review of Licensed Practical Nurse (LPN) J's Witness Statement dated 11/26/2023, revealed .CNA I brought [Resident #18] and [Resident #17] to desk .[Resident #18] had a scratch on right cheek .[Resident #17] had an open area on right fourth finger .[Resident #17] stated [Resident #18] came into her [Resident #17] room . when she [Resident #17] told her [Resident #18] to get out [Resident #18] grabbed her hand [Resident #17] and twisted it .[Resident #18] wouldn't let go .so she [Resident #17] scratched her [Resident #18] on left cheek .[Resident #18] was placed behind desk with staff .[Resident #17] was on the other side of desk . Review of the DON's Written Statement dated 11/27/2023, revealed .interviewed [Resident #17] at [8:20 AM] .what happened to your finger .[Resident #17] stated [Resident #18] came into my room .grabbed my [Resident #17] hand and twisted it .I wasn't putting up with it .so I [Resident #17] scratched her [Resident #18] face .asked if she [Resident #17] was afraid and [Resident #17] stated no .asked if she [Resident #17] felt safe .[Resident #17] stated yes . During an interview and observation on 7/29/2024 at 10:35 AM, Resident #17 stated she had been in an altercation with Resident #18. Resident #18 wandered into Resident #17's room and grabbed her arm. Resident #17 told Resident #18 to get out of her room, scratched Resident #18 across the cheek, and Resident #18 left the room. Resident #17 stated Resident #18 cut her right finger. Resident #17 stated the nurse applied treatment to her finger. Resident #17 stated staff offered to relocate her to the 1st floor, but the resident refused because she wanted to stay in her room. Resident #17 stated that she felt safe in the facility, was not afraid, and the facility placed a stop sign across her doorway to keep Resident #18 out of her room. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/2024 at 8:35 AM, LPN J stated she worked on 11/26/2023 when the incident between Resident #17 and #18 occurred. CNA I brought the residents to the nurses desk, Resident #17 had small skin tear on her right finger, and Resident #18 had a scratch to her right cheek. LPN J stated Resident #17 informed the LPN Resident #18 walked into her room and grabbed her [Resident #17] arm resulting in a skin tear to her finger and Resident #17 scratched Resident #18's face after Resident #18 grabbed her finger. LPN J stated the residents were immediately separated and a head-to-toe assessment was completed on both residents. Resident #18 was placed on 1:1 supervision, Resident #17 was offered to move to another location in the facility, the resident declined and wanted to stay in her room. During an interview on 7/30/2024 at 2:00 PM, the DON stated Resident #17 and Resident #18 had an altercation on 11/26/2023. Resident #18 entered Resident #17's room, Resident #17 told Resident #18 to leave, and Resident #18 grabbed Resident #17's arm causing a skin tear to the resident's right finger. Resident #17 stated when Resident #18 grabbed her arm the resident scratched Resident 18's face. The facility offered to move Resident #17 to another area of the facility but Resident #17 declined. The facility placed a STOP sign on Resident #17's door to prevent other residents from entering her room. The DON stated Residents #17 and #18 did not have any behavioral changes after the altercation. The DON confirmed that the facility substantiated the resident-to-resident altercation between Resident #17 and Resident #18 and both residents were harmed. 37078 3. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Depressive Disorder, and Intellectual Disabilities. Review of a quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 13 on the BIMS which indicated the resident was cognitively intact. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] with diagnoses including Need for Assistance with Personal Care, Anxiety Disorder, and Depressive Disorder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 scored a 15 on the BIMS which indicated the resident was cognitively intact. Review of the facility's investigation revealed on 3/15/2024 at 1:15 PM, the Activities Director witnessed Resident #6 hit Resident #5 with a soda can in Resident #5's upper chest. Resident #6 was upset because Resident #5 touched her drink. Assessment and interview with Resident #5 revealed the resident was not injured and was not upset by the incident. During an interview on 7/29/2024 at 10:00 AM, Resident #6 stated, .I told her [Resident #5] not to put her hands on my food. I hit her cause [because] I told her not to do it she put her hands on my drink .I just reached up and hit her . During an interview on 7/30/2024 at 8:00 AM, Resident #5 stated, .I picked up a soda can and [Resident #6] don't like her stuff touched .she [Resident #6] hit me [Resident #5] on the chest with it [soda can] it was empty it didn't hurt me or nothing .no [it didn't leave a mark or nothing] .oh yes [feels safe at the facility] . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/2024 at 1:45 PM, the Administrator confirmed Resident #6 hit Resident #5 on the chest with a soda can.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568 Based on review of facility policy review, medical record review, and interview, the facility failed to ensure physician orders were followed for 1 resident (Resident #26) of 15 residents reviewed. The findings include: Review of the facility's policy titled, .Medication Errors ., revised 1/24/2024, revealed .facility shall ensure medications will be administered .according to physician's orders . Review of the medical record revealed Resident #26 was admitted to the facility on [DATE] with diagnoses including Acute Respiratory Failure, COPD, Major Depressive Disorder, and Dysphagia. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #26 scored a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact. Review of a physician's order for Resident #26 dated 6/28/2024, revealed an order for Lorazepam (Ativan- an antianxiety medication) 0.5 mg (milligrams) by mouth every 4 hours as needed for anxiety/seizure precaution for 14 days. The end date for the medication was 7/12/2024. Review of the Narcotic Log for Resident #26 revealed Lorazepam 0.5 mg was removed from the medication cart on 7/23/2024 at 12:00 AM. During an interview on 7/31/2024 at 12:05 PM, Registered Nurse (RN) K confirmed Resident #26 physician's order for Lorazepam 0.5mg by mouth every 4 hours as needed for anxiety had been discontinued on 7/12/2024. During an interview on 7/31/2024 at 1:19 PM, Licensed Practical Nurse (LPN) L confirmed Resident #26 had received Lorazepam 0.5mg on 7/23/2024 at 12:00 AM. During an interview on 7/31/2024 at 1:25 PM, RN K confirmed that Resident #26 had been given Lorazepam 0.5mg on 7/23/2024 at 12:00 AM, without a physician's order.