

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Greystone Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record reviews, and interviews, the facility failed to ensure appropriate and timely Notice of Medicare Non-Coverage (NOMNC) Form CMS-10123 and Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) Form CMS-10055 were provided to 4 residents (Resident #20, Resident #42, Resident #60 and Resident #103) of 6 residents reviewed for beneficiary notices. The findings include: Review of the facility policy titled, Advance Beneficiary Notices, revised 10/30/2023, revealed .It is the policy of this facility to provide timely notices regarding Medicare eligibility and coverage .For Part A items and services, the facility shall use the Skilled Nursing Facility Advance Beneficiary Notice .Form CMS-10055 .A Notice of Medicare Non-Coverage .Form CMS-10123, shall be issued to the resident/representative when Medicare covered service(s) are ending, no matter if resident is leaving the facility or remaining in the facility .the notice shall be provided within two days of the last anticipated covered day . Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Acute and Chronic Respiratory Failure, and Congestive Heart Failure. Review of a discharge Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 discharged from the facility on 6/8/2026. Review of the medical record for Resident #20 revealed no documentation a NOMNC or SNFABN was provided to the resident or resident representative. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease, Heart Disease, and Hypothyroidism. Review of an End of a Part A stay MDS assessment dated [DATE], revealed Resident #42's Medicare Part A Stay ended on 7/15/2026 and the resident remained at the facility. Review of the medical record for Resident #42 revealed no documentation a NOMNC or SNFABN was provided to the resident or resident representative. Review of the medical record revealed Resident #60 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Chronic Kidney Disease, and Spinal Stenosis. Review of a Modification of End of a Part A Stay MDS assessment dated [DATE], revealed Resident #60's Medicare Part A Stay ended on 5/15/2026. Review of the NOMNC form revealed Resident #60 signed the form on 5/15/2026 and services ended on 5/15/2026. The notice was not provided within two days of the last anticipated covered day. Review of the medical record revealed Resident #103 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Muscle Weakness, and Chronic Pain Syndrome. Review of an End of PPS Part A Stay MDS assessment dated [DATE], revealed Resident #103's Medicare Part A Stay ended on 5/29/2026. Review of the medical record for Resident #103 revealed no documentation a NOMNC or SNFABN was provided to the resident or resident representative. During an interview on 7/22/2026 at 9:25 AM, the Social Service Director stated she was responsible for the completion of the CMS Forms and confirmed SNFABN Form CMS-10055 was not completed for Resident #20, Resident #42, Resident (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#60, and Resident #103 and NOMNC Form CMS-10123 was not provided within two days of the last anticipated covered day for Resident #103. During an interview on 7/22/2026 at 9:35 AM, the Administrator stated his expectation was for the appropriate forms to be completed within the correct time frame.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Centers for Medicare and (&) Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1 review, medical record reviews, observations, and interviews, the facility failed to accurately code a Minimum Data Set (MDS) assessment for Pre-admission Screening and Resident Review (PASRR) for 4 residents (Resident #14, #42 #108 and #12) of 36 residents reviewed for MDS assessment accuracy. The findings include: Review of Centers for Medicare and Medicaid Services Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.20.1, dated 10/2025, revealed .primary purpose as an assessment instrument is to identify resident care problems .the assessment [MDS] accurately reflects the resident's status .A1500 .Preadmission Screening and Resident Review [PASRR] .Code .yes .if PASRR Level II screening determined that the resident has a serious mental illness . Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Schizophrenia, Depression, and Hypertension. Review of a Notice of PASRR Level II Outcome for Resident #14 dated 9/17/2025, revealed .You had a Level II PASRR evaluation .you need special services for your mental health .your PASRR Level II evaluation remains good during your stay . Review of an annual MDS assessment dated [DATE] revealed Resident #14 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed .Is the resident currently considered by the state Level II PASRR process to have a serious mental illness .No . During an observation and interview on 7/22/2026 at 9:50 AM, the Licensed Practice Nurse/MDS Coordinator reviewed the Level II PASRR outcome and the annual MDS assessment for Resident #14 and confirmed the MDS assessment had not been coded correctly to reflect the Level II PASRR. Review of the medical record revealed Resident #42 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Vascular Dementia, Bipolar Disorder, and Chronic Obstructive Pulmonary Disease. Review of a Notice of PASRR Level II Outcome for Resident #42 dated 2/20/2025 (prior to admission), revealed .You had a Level II PASRR evaluation .you need special services for your mental health your PASRR Level II evaluation remains good during your stay . Review of an annual MDS assessment dated [DATE], revealed Resident #42 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed .Is the resident currently considered by the state level II PASRR process to have a serious mental illness .or a related condition .No . (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/22/2026 at 2:57 PM, the Registered Nurse (RN) MDS Coordinator reviewed the Level II PASRR outcome and the annual MDS assessment for Resident #108 and confirmed the MDS assessment had not been coded correctly to reflect the Level II PASRR. During an interview on 7/22/2026 at 3:58 PM, the Director of Nursing confirmed it was her expectation for the MDS assessment to be coded to accurately reflect the resident's Level II PASRR status. Review of the medical record revealed Resident #108 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Major Depressive Disorder, Impulse Disorder, Unspecified Psychosis, and Mild Intellectual Disabilities. Review of a Notice of PASRR Level II Outcome for Resident #108 dated 12/18/2019, revealed .You had a Level II PASRR evaluation .you need special services for your mental health, intellectual disabilities or related condition .your PASRR Level II evaluation remains good during your stay . Review of a significant change in status MDS assessment dated [DATE], revealed Resident #108 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed .Is the resident currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition .No . During an observation and interview on 7/22/2026 at 2:57 PM, the RN MDS Coordinator reviewed the Level II PASRR outcome and the significant change MDS assessment for Resident #108 and confirmed the MDS assessment had not been coded correctly to reflect the Level II PASRR. During an interview on 7/22/2026 at 3:58 PM, the Director of Nursing confirmed it was her expectation for the MDS assessment to be coded to accurately reflect the resident's Level II PASRR status. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Delusional Disorder, Anxiety Disorder, and Psychosis. Review of a Notice of PASRR Level II Outcome for Resident #12 dated 8/15/2023, revealed .You had a Level II PASRR evaluation .you need special services for your mental health .your PASRR Level II evaluation remains good during your stay . Review of an annual MDS assessment dated [DATE], revealed Resident #12 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed .Is the resident currently considered by the state Level II PASRR process to have a serious mental illness .No . Further review revealed Resident #12 had diagnoses of Anxiety Disorder, Depression, and Psychotic Disorder coded on the MDS assessment. During an observation and interview on 7/22/2026 at 2:50 PM, the RN MDS Coordinator reviewed the Level II PASRR and annual MDS assessment for Resident #12 and confirmed the annual MDS (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interviews, the facility failed to develop a care plan for 1 resident (Resident #40) of 36 residents reviewed for care planning. The findings include: Review of the facility's policy titled, Comprehensive Care Plans, revised 6/30/2022 revealed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident . Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Quadriplegia, Diabetes Mellitus, and Severe Protein-Calorie Malnutrition. Review of a comprehensive care plan for Resident #40 revised 7/9/2026, revealed the resident's Stage IV (4) pressure ulcer was not addressed on the comprehensive care plan. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed the resident had a Stage IV pressure ulcer. During an interview on 7/22/2026 at 3:07 PM, the Registered Nurse (RN) MDS Coordinator confirmed Resident #40 did not have a comprehensive care plan developed for the Stage IV pressure ulcer.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, and interview, the facility failed to revise a care plan for 1 resident (Resident #95) for respiratory interventions of 16 care plans reviewed. The findings include: Review of the facility policy titled, Comprehensive Care Plans, revised 6/30/2022, revealed .policy of this facility .implement .comprehensive person-centered care plan .to meet a resident's medical .needs that are identified in .resident's .Minimum Data Set . Review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy, Tracheostomy (a surgically created opening in the front of the neck leading to the windpipe/trachea for breathing) Status, and Chronic Obstructive Pulmonary Disease (COPD). Review of the Physician's Order for Resident #95 dated 7/18/2024, revealed .Trach [Tracheostomy] Change. Trach [Tracheostomy] .one time a day .for Routine Trach Care related to TRACHEOSTOMY STATUS .and as needed for Trach Change .Suction tracheostomy as needed .Use sterile saline lavage .Trach tie change with baths and as needed .Trach care every shift and as needed .change inner cannula every shift and as needed . Review of an annual Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #95 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review indicated Resident #95 had a tracheostomy. Review of a comprehensive care plan for Resident #95 dated 7/18/2026, revealed .Resident has an impaired .respiratory status related to dx [diagnosis] of COPD, trach [trachesotomy] status and respiratory failure .Oxygen as ordered .Ensure trach ties are secured . During an interview on 7/22/2026 at 2:15 PM, the Registered Nurse (RN) MDS Coordinator confirmed the care plan for Resident #95 had not been revised to reflect tracheostomy care. During an interview on 7/22/2026 at 3:50 PM, the Director of Nursing confirmed she would expect care plans to be revised with tracheostomy care and confirmed Resident #95's care plan had not been revised to reflect the tracheostomy care.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record reviews, observations, and interviews, the facility failed to ensure the environment was free of accidental hazards for 1 resident (Resident #5) when an unsecured scalpel (a small extremely sharp instrument used in surgery, anatomical dissection, and podiatry) was observed on the bedside table and failed to secure medications for 3 residents (Resident #12, #54, and Resident #111) of 36 residents reviewed for accident hazards. The findings include: Review of the facility's policy titled, Sharps Disposal, revised 10/30/2023, revealed .Contaminated sharps will discard them immediately or as soon as feasible into designated containers . Review of the facility's policy titled, Medication Storage, revised 1/30/2024, revealed .medication must be under the direct observation of the person administering medications or locked in the medication storage area/cart . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Lack of Coordination, Muscle Weakness, and Acute Respiratory Failure. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #5 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated resident was cognitively intact. Review of a physician's progress note for Resident #5 dated 7/16/2026, revealed .15 blade [sharp] was used to surgically excise [remove] devitalized [dead] tissue . During an observation and interview in Resident #5's room on 7/20/2026 at 12:42 PM, revealed a scalpel on the nightstand beside the resident's bed. Resident #5 stated the scalpel looked like the one used by the wound care during a wound care treatment to his toe (unsure of exact date) and must have left the scalpel on his bedside table but was unsure if the particular scalpel observed had been used. Resident #5 stated he recently broke his leg, stayed in bed at all times, and there were no residents who wandered into his room. During an observation and interview in Resident #5's room on 7/20/2026 at 1:39 PM, Certified Nursing Assistant (CNA) E stated the object on the bedside table was a scalpel and there were no residents with wandering behaviors on the hall. During an observation and interview in Resident #5's room on 7/20/2026 at 1:42 PM, Licensed Practical Nurse (LPN) H confirmed a scalpel was on the residents bedside table, removed the scalpel, and disposed of the scalpel in the sharp's disposal box located in the resident's room. During an interview on 7/20/2026 at 3:45 PM, the Director of Nursing stated it was her expectation sharps be disposed of immediately in the appropriate containers once used. Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Delusional Disorder, Anxiety Disorder, and Psychosis. Review of an annual MDS assessment dated [DATE], revealed Resident #12 scored a 15 on the BIMS assessment which indicated resident was cognitively intact. Review of the medical record for Resident #12 revealed no documentation Resident #12 had been assessed to self-administer topical medications. During an observation in Resident #12's room on 7/22/2026 at 9:00 AM, revealed a tube of Nystatin Cream on the resident's bedside table. During an observation and interview in Resident #12's room on 7/22/2026 at 3:35 PM, with Registered Nurse (RN) A revealed a tube of Nystatin Cream on the resident' bedside table. RN A confirmed the Nystatin Cream at the resident's bedside and should not be on the bedside table. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] with diagnoses including Diabetes, Chronic Obstructive Pulmonary Disease, and Heart Failure. Review of a quarterly MDS assessment dated [DATE], revealed Resident #54 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of a (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive care plan for Resident #54 dated 7/15/2026, revealed Resident #54 was not care planned to self-administer medications. During an observation in Resident #54's room on 7/20/2026 at 11:40 AM, revealed a plastic container of antacid tablets and a container of VapoRub on the resident's bedside table. During an observation and interview in Resident #54's room on 7/20/2026 at 4:10 PM, with LPN H revealed a plastic container of antacid tablets and a container of VapoRub on the resident's bedside table and LPN H removed the medication. LPN H confirmed Resident #54 had not been assessed to self- administer medications. Review of the medical record revealed Resident #111 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Congestive Heart Failure, and Depression. Review of the Physician's Orders for Resident #111 dated 3/11/2026, revealed .Insulin Glargine [medication used to treat high blood sugar] Pen-Injector 100 UNIT/ML [milliliter] .Inject 22 unit .two times a day for DM [Diabetes Mellitus] . Review of an annual MDS assessment dated [DATE], revealed Resident #111 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed the resident had a diagnosis of Diabetes and had received insulin injections during the assessment period. Review of a Medication Administration Record (MAR) for Resident #111 dated 7/1/2026-7/31/2026, revealed the resident received Insulin Glargine twice a day as ordered. During an observation and interview in Resident #111's room on 7/21/2026 at 8:05 AM, a Glargine insulin pen was observed to be lying on the dresser next to the resident's bed. Resident #111 stated the nurse had administered the medication (insulin) this morning.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, observations, and interview the facility failed to serve a meal tray timely for 1 resident (Resident #9) of 3 residents reviewed for meal tray distribution. The findings include: Review of the facility's policy titled, Meal Distribution, revised 2/2023, revealed .Meals are .delivered in a timely .manner .nursing staff will be responsible for the .timely delivery of meals to residents . Review of the medical record revealed Resident #9 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure, and Atrial Fibrillation. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #9 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #12 required set-up or clean-up assistance with eating. Review of a comprehensive care plan for Resident #9 revised 7/6/2026, revealed .Resident has an ADL [Activities of Daily Living] self-care performance deficit related to .COPD .needs will be met .EATING: Independent - offer assistance with meal setup as needed . During an interview and observation on 7/21/2026 at 7:50 AM, Resident #9 stated .I am ready to get my breakfast tray and especially some coffee . Observation revealed the breakfast meal trays were on meal carts on the hallway and was being delivered to the residents. During an observation on 7/21/2026 at 8:15 AM (25 minutes later), Resident #9 did not have a breakfast tray. Continued observation the other residents on the hallway had been served. During an interview on 7/21/2026 at 8:17 AM, Certified Nursing Assistant (CNA) E stated that he had not served Resident #9's breakfast tray nor did he know who had. During an interview on 7/21/2026 at 8:20 AM, CNA M stated that someone had taken Resident #9's breakfast and the resident had refused (later discovered the resident had not refused). During an interview on 7/21/2026 at 8:25 AM, the Wound Care nurse stated she had not delivered Resident #9's breakfast tray. During an interview on 7/21/2026 at 8:35 AM (approximately 45 minutes after meal delivery service began), CNA E and CNA N confirmed Resident #9's breakfast tray was still on the food cart. CNA E confirmed Resident #9's breakfast tray had not been served timely. During an interview on 7/21/2026 at 8:36 AM, Resident #9 stated he had not received a breakfast tray. During an observation on 7/21/2026 at 8:37 AM, CNA E served Resident #9's breakfast tray. CNA E heated the resident's breakfast try and provided coffee. During an interview on 7/21/2026 at 8:49 AM, LPN L confirmed Resident #9 had not been served breakfast timely. During an interview on 7/22/2026 at 4:51 PM, the Director of Nursing confirmed Resident #9 had not been served breakfast timely on 7/21/2026.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy reviews, medical record reviews, observations, and interviews the facility failed to ensure oxygen was administered according to Physician's Orders for 2 residents (Residents #20 and #19) of 10 residents reviewed for oxygen (O2) therapy, the facility failed to maintain infection control practices during tracheostomy (trach) (a surgically created opening in the front of the neck leading to the windpipe/trachea for breathing) care and failed to perform tracheostomy care appropriately for 1 resident (Resident #95) of 4 residents reviewed for tracheostomies. The findings include: Review of the facility policy titled, Oxygen Administration, revised 10/26/2023, revealed .Oxygen is administered to residents who need it .Oxygen therapy .administered under orders of a physician . Review of the facility policy titled, Tracheostomy Care, revised 10/26/2023, revealed .facility will ensure that residents who need respiratory care .tracheostomy care and tracheal suctioning .provided .with professional standards of practice .remove old dressing .discard .appropriate receptacle .perform hand hygiene .clean the stoma with normal saline moistened gauze .dry the area with additional gauze . Review of the facility policy titled, Sterile Suction, revised 6/23/2025, revealed .tracheal suctioning with a catheter inserted .artificial airway .effective strategy .important for resident comfort . Review of the facility policy titled, Hand Hygiene, revised 5/11/2026, revealed .staff will perform proper hand hygiene .to prevent the spread of infection to .residents .the use of gloves does not replace hand hygiene .if your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves . Review of the medical record revealed Resident #20 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Acute and Chronic Respiratory Failure, and Congestive Heart Failure. Review of the Physician's Order for Resident #20 dated 3/31/2026, revealed .oxygen .run @ [at] 2L [Liters]/Min [Minute] via [by way of] N/C [nasal cannula] continuous .related to COPD . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #20 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed Resident #20 had received oxygen. Review of a comprehensive care plan for Resident #20 dated 7/3/2026, revealed .Resident has an impaired pulmonary/respiratory status related to COPD .Oxygen as ordered . During an observation on 7/21/2026 at 4:11 PM, in Resident #20's room revealed the resident lying in bed with O2 tubing in place and had a portable O2 tank secured on the back of the resident's wheelchair at the bedside. Further observation revealed the O2 tank was empty, and the resident had no signs of respiratory distress. During an interview on 7/21/2026 at 4:13 PM, Registered Nurse (RN) B confirmed Resident #20's O2 tank was empty. RN B obtained Resident #20's O2 saturation level, and it was 95% (Normal O2 saturation for a resident with COPD ranges from 88%-92%). Review of the medical record revealed Resident #19 was admitted to the facility on [DATE] with diagnoses including Chronic Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. Review of the Physician's Order for Resident #19 dated 11/15/2025, revealed .Oxygen .run @ 1 L/Min via trach[tracheostomy] .continuous .related to COPD . Review of a comprehensive care plan for Resident #19 dated 6/14/2026, revealed .Resident has an impaired respiratory status related to .COPD .Oxygen as ordered . Review of a quarterly MDS assessment dated [DATE], revealed Resident #19 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Further review revealed Resident #19 received O2. During an observation on 7/22/2026 at 7:31 AM, in Resident #19's room revealed the resident sitting up in a wheelchair with O2 tubing in place and a portable O2 tank secured (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Greystone Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 181 Dunlap Road Blountville, TN 37617	
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on the back of the resident's wheelchair. Further observation revealed the O2 tank was empty, and the resident had no signs of respiratory distress. During an interview and observation on 7/22/2026 at 7:32 AM, RN J confirmed Resident #19 had physician orders for continuous O2 and confirmed the O2 tank was empty. RN J obtained Resident #19's O2 saturation level, and it was 98%. Review of the medical record revealed Resident #95 was admitted to the facility on [DATE] with diagnoses including Cerebral Palsy, Tracheostomy Status, and COPD. Review of the Physician's Order for Resident #95 dated 7/18/2024, revealed .Trach Change .one time a day .for Routine Trach Care related to TRACHEOSTOMY STATUS .and as needed for Trach Change .Suction tracheostomy as needed .Use sterile saline lavage .Trach tie change with baths and as needed .Trach care every shift and as needed .Change inner cannula every shift and as needed . Review of an annual MDS assessment dated [DATE], revealed Resident #95 scored a 10 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review indicated Resident #95 had a tracheostomy. Review of a comprehensive care plan for Resident #95 dated 7/18/2026, revealed .Resident has an impaired .respiratory status related to dx [diagnosis] of COPD, trach [tracheostomy] status and respiratory failure .Oxygen as ordered .Ensure trach ties are secured . During an observation in Resident #95's room on 7/22/2026 at 7:43 AM, revealed Respiratory Therapist (RT) I performed trach care. RT donned appropriate Personal Protective Equipment (PPE), removed single use inner cannula, performed in-line suctioning with single use sterile water already attached to tubing, removed gloves, donned gloves, replaced new single use inner cannula, removed old dressing around trach (tracheostomy) site, and replaced clean dressing around trach stoma. Observation revealed RT I did not clean the hands between the glove changes. During an interview on 7/22/2026 at 7:47 AM, RT I confirmed that she had not cleaned around Resident #95's trach stoma and had not utilized new single use sterile saline for suctioning the resident. During an interview on 7/22/2026 at 8:09 AM, RT I confirmed she did not wash her hands when she changed gloves during tracheostomy care for Resident #95. RT I asked, .should I have sanitized my hands between glove change . During an interview on 7/22/2026 at 4:51 PM, the Director of Nursing confirmed she would expect hands to be sanitized between glove changes, new single use sterile saline utilized when suctioning resident's tracheostomy, and trach stoma should be cleaned when changing out the gauze.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **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 check refrigerator temperatures for 3 resident's (Resident #25, Resident #73, and Resident #104) and failed to ensure expired food items were discarded for 1 resident (Resident #104) of 7 personal refrigerators observed. The findings include: Review of the facility's policy titled, Resident Refrigerators, revised 7/1/2025 revealed .Housekeeping staff shall record refrigerator temperatures daily on a temperature log attached to the refrigerator .Housekeeping staff shall clean the refrigerator daily and discard any foods that are out of compliance . Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] with diagnoses including Chronic Obstructive Pulmonary Disease and Depression. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #25 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of a personal refrigerator temperature log for Resident #25 revealed temperatures were not documented on the following days: April 1st, 2nd, 6th, 7th, 10th, 11th, 12th, 15th, 16th, 17th, 18th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th 2026. Further review revealed temperatures were not documented on the following days: May 1st, 2nd, 3rd, 4th, 8th, 9th, 10th, 26th, and 28th 2026. Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Cirrhosis of Liver, Schizophrenia, Anxiety Disorder, and Depression. Review of a quarterly MDS assessment dated [DATE], revealed Resident #73 scored a 14 on the BIMS assessment which indicated the resident was cognitively intact. Review of a personal refrigerator temperature log for Resident #73 revealed temperatures were not documented on the following days: April 1st, 2nd, 6th, 7th, 10th, 11th, 14th, 15th, 16th, 17th, 18th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, and 30th 2026. Further review revealed temperatures were not documented on the following days: May 1st, 2nd, 3rd, 4th, 8th, 9th, 10th, 26th, and 28th 2026. Review of the medical record revealed Resident #104 was admitted to the facility on [DATE] with diagnoses including Spinal Stenosis, Generalized Muscle Weakness, and Chronic Pain Syndrome. Review of a quarterly MDS assessment dated [DATE], revealed Resident #104 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. During an observation and interview on 7/20/2026 at 3:37 PM in Resident #104's room revealed a personal refrigerator with expired items. Further review revealed 1 carton of milk expired on 6/22/2026, and 1 carton of milk had expired on 7/13/2026. Resident #104 stated she did not know who was responsible for checking the refrigerator temperatures, cleaning out her refrigerator, or ensuring expired foods were disposed of properly. Further observation revealed no temperature log on the refrigerator. During an interview and observation in Resident 104's room on 7/20/2026 at 4:09 PM, Licensed Practical Nurse (LPN) D stated all staff were responsible for keeping the residents' personal refrigerators clean and disposing of expired items. LPN D also stated the temperature logs for the residents' personal refrigerators were supposed to be checked daily, with the temperature logs kept at the nurse's station. LPN D confirmed the 2 cartons of milk were expired, and available for resident use. LPN D removed the expired milk. Review of a personal refrigerator temperature log for Resident #104 revealed temperatures were not documented on the following days: April 1st, 2nd, 6th, 10th, 11th, 12th, 15th, 16th, 17th, 18th, 20th, 21st, 22nd, 23rd, 24th, 25th, 26th, 27th, 28th, 29th, 30th 2026. Further review revealed temperatures were not documented on the following days: May 1st, 2nd, 3rd, 4th, 8th, 9th, 10th, 26th, and 28th 2026. During an interview on 7/22/2026 at 4:00 PM, the Director of (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing confirmed the residents' personal refrigerators were to be cleaned, expired food items to be checked and disposed when expired, and temperatures to be checked and documented daily.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility contract review, medical record review, and interviews, the facility failed to ensure communication between the facility and hospice services for 1 resident (Resident #16) of 3 residents reviewed for hospice services. The findings include: Review of a Nursing Facility Services Agreement dated 4/15/2010, revealed .Hospice and Facility will jointly develop and agree upon a coordinated Plan of Care .Coordination of Care .Facility shall participate in .meetings .for the coordination, supervision, and evaluation by Hospice of the provision of Facility Services. Hospice and Facility shall communicate with one another regularly .for each particular Hospice Patient . Review of the facility's policy titled, Hospice, revised 10/26/2023, revealed .When a resident chooses to receive hospice care .the facility will coordinate .in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being .The facility will communicate with hospice and identify, communicate, follow and document all interventions put into place by hospice and the facility .The facility will maintain communication with hospice as it relates to the resident's plan of care and services to ensure each entity is aware of their responsibilities . Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] with diagnoses including Encounter for Palliative Care, Dementia, and Cerebrovascular Disease. Review of the Physician's Orders for Resident #16 dated 2/18/2026, revealed .Admit to Hospice . Review of a comprehensive care plan for Resident #16 dated 2/19/2026, revealed .has a terminal prognosis with Amedysis Hospice Care related to end of life diagnosis senile deterioration of brain . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #16 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and the resident received hospice care. During an interview on 7/22/2026 at 7:58 AM, the Social Service Director (SSD) stated Amedisys staff contacted the facility when they wanted to have a care plan meeting to discuss coordination of care for residents who received hospice services. The SSD also stated there was no documentation of a coordinated care plan meeting between the facility and the hospice provider for Resident #16. During an interview on 7/22/2026 at 4:10 PM, the SSD stated there was a care plan meeting scheduled for Resident #16 on 7/23/2026 with Amedisys hospice and .moving forward we [facility] will have monthly care plan meetings . with Amedisys hospice to discuss coordination of care for all residents who received hospice services. During an interview on 7/22/2026 at 4:13 PM, the Director of Nursing confirmed the facility failed to ensure coordination of care between the facility and hospice for Resident #16.		

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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, disinfectant label review, medical record review, observation, and interview, the facility failed to ensure a glucometer (blood glucose machine) (a handheld device used to measure blood glucose levels, to assist with the management of Diabetes) was sanitized after each use for 2 residents (Resident #54 and #5), failed to follow infection control practices during 1 of 2 medication administration observations for 2 Residents (Resident #54 and #5) and failed to follow infection control practices during wound care for 1 resident (Resident #40) of 2 residents observed for wound care. The findings include: Review of the facility policy titled, Medication Administration, dated 1/17/2023, revealed .Medications are administered by licensed nurses .as ordered by the physician.in a manner to prevent contamination or infection .Remove medication .taking care not to touch medication with bare hand .Administer medication .Observe resident consumption of medication .Wash hands . Review of the facility policy titled, Blood Glucose Machine Disinfection, dated 4/2/2026, revealed .The purpose of this procedure is to provide guidelines for the disinfection of blood sampling devices to prevent transmission of blood borne diseases to residents and employees .The facility will ensure blood glucose machines [glucometers] will be disinfected after each use .The blood glucose machine should be disinfected with a wipe pre-saturated with . healthcare disinfectant that is effective against HIV [Human Immunodeficiency Virus], Hepatitis C and Hepatitis B virus . Review of the facility policy's titled, Hand Hygiene, dated 5/11/2026, revealed .All staff will perform proper hand hygiene procedures to prevent the spread of infection to other .residents .Staff will perform hand hygiene when indicated .After handling contaminated objects . Review of a Super Sani-Cloth Germicidal Disposable Wipe (Environmental Protection Agency (EPA) registered healthcare disinfectant wipe used to clean glucometers) label revealed .Effective against .Bloodborne Pathogens .Hepatitis B virus .Hepatitis C virus .HIV .virus . 1. Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes, Congestive Heart Failure, and Autistic Disorder. 1 a. Review of the Physician's Orders for Resident #54 dated 7/9/2026, revealed .Furosemide [Lasix] [medication used to treat Heart Failure] .20 MG [milligram] .by mouth one time a day related to HEART FAILURE .Insulin Lispro .[medication used to treat Diabetes]100 unit/ml [per milliliter] .Inject 5 unit [s] .before meals related to Diabetes . 2. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Diabetes, Hypertension, and Atrial Fibrillation. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 a. Review of the Physician's Orders for Resident #5 dated 7/1/2026, revealed .Insulin Lispro .100 unit/ml . Inject per sliding scale .151-200 .2 [administer 2 units] .Potassium Chloride ER [extended release] [supplement used to prevent or treat low blood levels of potassium] Oral Tablet .20 MEQ [milliequivalent] .Give 1 tablet by mouth two times a day for supplement . During an observation and interview of medication administration on 7/21/2026 at 7:50 AM, revealed Registered Nurse (RN) K prepared oral medications for Resident #54 and then stated she needed to check the residents blood glucose level before she administered the medications. RN K placed a small plastic cup of medications labeled with Resident #54's name in the medication cart, locked the cart, donned gloves, and entered the resident's room. RN K checked the resident's blood glucose level using a glucometer. Resident #54 informed RN K he did not want his Lasix administered today because he was going out to eat. RN K removed her gloves and exited the room without washing or sanitizing her hands. Further observation revealed RN K placed the glucometer on top of the medication cart, retrieved Resident #54's medication, removed the Lasix 20 mg tablet from the small plastic cup with her bare hands, and prepared the resident's insulin medication. RN K re-entered Resident #54's room, administered the remaining oral medications, donned gloves, administered the Lispro insulin 5 units, removed her gloves, and exited the room without washing or sanitizing her hands. Continued observation at 8:20 AM, revealed RN K prepared medications for Resident #5, the RN removed Potassium 20 MEQ from the small plastic cup and broke the pill in half with her bare hands and placed the medication back in the cup. The RN entered Resident #5's room, administered oral medications to the resident and exited the room without washing or sanitizing her hands. RN K retrieved the non-sanitized glucometer (used previously for Resident #54) off the medication cart, re-entered Resident #5's room, donned gloves, checked the resident's blood glucose level using the non-sanitized glucometer, removed the gloves, and exited the room without washing or sanitizing her hands. RN K placed the glucometer on top of the medication cart and failed to sanitize the blood glucose machine. RN K stated the facility protocol for sanitizing glucometers was to use Sani-wipes with the purple lid to disinfect the glucometers and were to be disinfected after each resident use. RN K confirmed she failed to follow proper infection control practices when she failed to wash or sanitize her hands when she administered medications to Resident #54 and #5, when she touched Resident #54 and #5's medication with her bare hands, and when she failed to sanitize the glucometer after each resident use. During an interview on 7/21/2026 at 8:45 AM, the Assistant Director of Nursing (ADON) confirmed glucometers were to be sanitized after each use. During an interview on 7/22/2026 at 4:07 PM, the Director of Nursing (DON) confirmed RN K failed to follow proper infection control practices during the medication administration of Residents #54 and #5 and failed to disinfect the glucometer after each resident use. Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Quadriplegia, Diabetes Mellitus, and Severe Protein-Calorie Malnutrition. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #40 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 7/21/2026 at 10:53 AM, revealed the Wound Care Nurse prepared wound care supplies for Resident #40. Further observation revealed the Wound Care Nurse sanitized her hands, applied gloves, and removed the resident's soiled dressings using scissors from the resident's bilateral legs. The Wound Care Nurse failed to use the disinfectant to clean the scissors and placed the soiled scissors in her pocket. The Wound Care Nurse confirmed she placed soiled scissors in her pocket without using the disinfectant. Continued observation revealed no signs or symptoms of infection of Resident #40's bilateral extremities. During an interview on 7/22/2026 at 4:00 PM, the DON confirmed the Wound Care Nurse did not follow appropriate infection control practices during wound care for Resident #40.		

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **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 the call light was in reach for 2 residents (Resident #13 and Resident #108) of 35 residents reviewed. The findings include: Review of the facility policy titled, Call Lights: Accessibility and Timely Response, revised 12/28/2023, revealed .The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside .to allow resident to call for assistance .Staff are educated in the proper use of the resident call system .ensuring resident access to .call light . Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Post-Polio Syndrome, Footdrop Left, Mild Cognitive Impairment, Osteoarthritis and Age-Related Osteoporosis. Review of a comprehensive care plan for Resident #13 dated 5/24/2026, revealed resident had .ADL [Activities of Daily Living] self-care performance deficit related to .weakness, impaired mobility .OA [Osteoarthritis] .left foot drop, pain .Encourage resident to use call light when assistance is needed .Place call light within reach . Review of a significant change Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment and required substantial/maximal assistance on staff for ADL's and mobility. During an observation on 7/21/2026 at 8:15 AM, in Resident #13's room revealed the resident yelling out for assistance, lying in bed with the head of bed elevated, with her breakfast tray in front of her on the overbed table. Further observation revealed Resident #13's call light was on the floor out of reach of the resident. During an observation and interview in Resident #13's room on 7/21/2026 at 8:25 AM, revealed the resident requested assistance opening the milk carton. The call light was on the floor out of reach of the resident. The surveyor exited the room to get staff assistance. During an observation and interview in Resident #13's room on 7/21/2026 at 8:30 AM, with Registered Nurse (RN) B revealed the call light remained out of reach of the resident, the resident's milk had not been opened, and RN B opened the milk and placed the call light within the resident's reach. RN B confirmed Resident #13's call light was out of reach. Review of the medical record revealed Resident #108 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Need for Assistance with Personal Care, Other Abnormalities of Gait and Mobility, Impulse Disorder, and Mild Intellectual Disabilities. Review of a comprehensive care plan for Resident #108 revised 4/29/2026, revealed .at risk for falls/injury .Place call light within reach .Review of a quarterly MDS assessment dated [DATE], revealed Resident #108 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. During an observation in Resident #108's room on 7/20/2026 at 11:34 AM, revealed Resident #108 lying in bed. Further observation revealed Resident #108's call light was out of reach. During an observation in Resident #108's room on 7/20/2026 at 3:47 PM, revealed Resident #108 lying in bed. Further observation revealed Resident #108's call light was out of reach. During an observation and interview on 7/20/2026 at 3:49 PM, RN C confirmed Resident #108's call light was out of reach. During an interview on 7/22/2026 at 3:59 PM, the Director of Nursing confirmed it was her expectation for call lights to be placed within the residents' reach.		