STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445259	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit View of Rocky Top	204 Industrial Park Rd Rocky Top, TN 37769

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 - Minimal harm or potential for 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** 40606 Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to protect 2 residents (Resident #1 and Resident #3) from verbal abuse and failed to protect and prevent resident to resident abuse between 4 residents (Resident #27 and #28 and Resident #4 and Resident #22) of 21 residents reviewed for abuse. The findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, undated revealed .'Abuse' means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse .physical abuse, and mental abuse . 'Willful' means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Review of the facility's policy titled, Resident-to-Resident Altercations, dated ,d+[DATE], revealed .All altercations, including those that may represent resident-to-resident abuse, shall be investigated .Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercations .Complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record . Medical record review revealed Resident #1 was admitted to the facility on [DATE] and expired on [DATE] with diagnoses including Senile Degeneration of the Brain, Dementia, and Malignant Neoplasm of the Stomach. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview of Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of a Facility Reported Investigation (FRI) dated [DATE], revealed Resident #1 reported to facility staff CNA D was rude to her. (continued on next page)

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

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation documentation for the verbal abuse allegation made on [DATE], revealed Resident #1 had reported CNA D for an allegation of verbal abuse. Continued review revealed the facility had substantiated the allegation of verbal abuse between CNA D and Resident #1 during their investigation. Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Anemia, Unspecified Dementia, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Review of a facility investigation summary of resident interviews, conducted on [DATE] revealed Resident #3 reported CNA D was rude and talked down to him. During an interview on [DATE] at 9:00 AM, the Administrator/Abuse Coordinator confirmed the facility failed to protect Resident #1 and Resident #3 from verbal abuse. Medical record review revealed Resident #27 (an alleged perpetrator) was admitted to the facility on [DATE] with diagnoses including Dementia without Behavioral Disturbance, Seizures, Alcohol Dependence, Depression, Anxiety, Hemiplegia and Hemiparesis following Cerebrovascular Disease Affecting Left Non-Dominant Side. Review of the quarterly MDS assessment dated [DATE], revealed Resident #27 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the facility's investigation, undated, revealed .At approximately 1605 [4:05 PM], one of the nurses on duty was walking through dining room when another resident stopped and told her two residents were fighting. Nurse responded immediately to the residents and separated the two residents .When nurse asked resident (Resident #27) what happened he stated, 'hit me' and motioned a fist hitting his face . Medical record review of a Nurse's Progress Note dated [DATE] at 5:30 PM, revealed .Resident [#27] had altercation with another resident [#28] in dining room. Resident [#27] hit another resident [#28] in the face. Both residents were yelling at each other .Residents were separated upon incident and immediately checked for marks. Other resident [#28] had a scratch on face . Medical record review revealed Resident #28 (alleged victim) was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis Following Cerebral Infarction (Stroke) Affecting Left Non-Dominant Side, Cerebral Ischemia (impaired blood flow to brain), Depression, Vascular Dementia with Agitation, and Mental Disorder. Review of the quarterly MDS assessment dated [DATE], revealed Resident #28 scored a 7 on the BIMS assessment which indicated the resident had severe cognitive impairment. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility investigation, undated, revealed .At approximately 1605 [4:05 PM], one of the nurses on duty was walking through dining room when another resident stopped and told her two residents were fighting. Nurse responded immediately to the residents and separated the two residents .When this resident's nurse asked this resident (Resident #28) what happened, he stated the other resident [Resident #27] hit him in the face on right side. Resident [#28] stated he did not know what he did wrong that the other resident [Resident #27] just hit him . Medical record review of a Nurse's Progress Note dated [DATE] at 5:37 PM, revealed .Resident [#28] had altercation with another resident [#27] in dining room. Other resident [#27] did hit this resident [#28] in face. Small scratch noted on right upper lip . Review of the facility investigation, undated, revealed a physical altercation occurred between Resident #27 and Resident #28 on [DATE] at 4:05 PM in the dining room. Continued review revealed Resident #28 had sustained a scratch on his right upper lip following the incident on [DATE]. Further review revealed a resident-to-resident altercation of physical abuse had occurred between Resident #27 and Resident #28. During a telephone interview on [DATE] at 1:39 PM, Licensed Practical Nurse, (LPN H) stated a resident told LPN A 2 residents were fighting. LPN A separated the residents and notified LPN H and the Administration of the altercation. Resident #28 was placed on 1:1 observation with staff and Resident #27 was accompanied by staff to his hall . LPN H stated Resident #28 had a red mark on the right side of his cheek along his mustache along his mustache following the resident-to-resident altercation. During an interview on [DATE] at 3:30 PM, the Administrator confirmed the facility failed to protect Resident #28 from physical abuse following a resident-to-resident altercation. Medical record review revealed Resident #4 (alleged victim) was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Alzheimer's Disease, Hallucinations, and Delirium. Review of the quarterly MDS assessment dated [DATE], revealed Resident #4 had a BIMS score of 12 which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #22 (alleged perpetrator) was readmitted to the facility on [DATE], with diagnoses including Dementia, Other Behavioral Disturbance, Anxiety Disorder, and Encounter for Palliative Care. Review of the admission MDS assessment dated [DATE], revealed Resident #22 scored a 6 on the BIMS which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #22's facility investigation, dated [DATE] at 11:34 PM, showed .Incident .Nursing Description: I attempted to assist this resident [Resident #22] to room/bed around 1:55p [PM] after attempting to wonder [wander] into other residents [residents'] rooms. Resident appeared to be content lying in bed. Approximately 2p [2 PM] I heard another resident yelling for help. Upon observation this resident [Resident #22] was holding onto another resident [Resident #4] forearms getting pushed out of [room number]. Resident [#22] let go of one of the forearms [Resident #4's forearm] and reared back with a clenched fist. I [LPN D] was able to intervene before contact was made. Residents were immediately separated and placed in a safe quite [quiet] environment. Upon assessment a scratch and bruise was noted on Right side of neck near collar bone. Increased agitation and combativeness following the altercation. Attempted to redirect. Resident attempted to strike staff with fist and objects nearby including chairs . Immediate action taken .Redirection attempted multiple times with different interventions each time. No success. Made behaviors worse. Provided 1on 1. New orders received from NP [Nurse Practitioner] to increase [2 medications for behavior] . Injuries Report Post Incident .Injury type .Abrasion .Injury Location . Face-Forehead . Injury type .Bruise .Injury Location .Face-Forehead .Injury type .Scratch(es) . Injury Location .Right clavicle . Review of Resident #4's facility investigation, dated [DATE] at 11:55 PM, showed .Incident Description . Nursing Description: Approx. [approximately] 2 pm, I hear this resident [Resident #4] yelling for help. Upon observation, [Resident #4 's last name] was pushing another resident [Resident #22] out of room [resident room number]. The other resident [Resident #22] had a hold of [Resident #4's name] forearms. The other resident [Resident #22] had reared back with a clenched fist. I was able to intervene before contact was made. Residents were immediately separated to a safe environment .[Resident #4's name] experienced increased agitation following the incident .Resident Description: She [Resident #22] came into my room and tried to get into my bed, and I tried to tell her no and she wouldn't stop .Immediate Action Taken .Placed resident [Resident #4] into a safe environment. During an interview on [DATE] at 8:55 AM, the Administrator/Abuse Coordinator confirmed the facility failed to protect Residents #1 and #3 from verbal abuse by CNA D. The interview confirmed the facility failed to protect Residents #4, #11 and #27, #28 from physical abuse.

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(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 - Some	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** 40606 Based on facility policy review, medical record review, facility investigations, and interviews, the facility failed to ensure allegations of abuse were reported to the state agency within 2 hours for 6 residents (Residents #1, #3, #4, #22, #11, and #12) of 21 residents reviewed for abuse. The findings include: Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 2020, revealed . Reporting/Response. The facility will have written procedures that include .Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (. law enforcement when applicable) within specified time frames. Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or . Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury . Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of the Brain, Dementia, and Malignant Neoplasm of the Stomach and expired [DATE]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 9 on the Brief Interview Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of the facility's investigation dated [DATE], revealed Resident #1 reported to Certified Nurse Assistant (CNA) E she was afraid of CNA D and did not want CNA D to provide care for her. Review of the Facility Reported Incident (FRI) for Resident #1 revealed the facility submitted an allegation of staff to resident verbal abuse on [DATE] at 12:55 PM, to the state agency. Further review revealed the allegation occurred on [DATE] at 4:30 AM. The facility failed to report to the state agency within the 2-hour timeframe, there was a delay of 8 hours and 25 minutes between the time of the incident identification and the time the facility reported the incident to the state agency. During a telephone interview on [DATE] at 6:30 PM, Licensed Practical Nurse (LPN) F confirmed she notified the Director of Nursing Services (DNS) of Resident #1's allegation on [DATE] and the DNS informed LPN F she would notify the Administrator. Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Hemiplegia and Hemiparesis following Cerebral Infarction, Unspecified Dementia, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 had a BIMS score of 12 which indicated the resident had moderate cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on [DATE] at 6:30 PM, LPN F confirmed she notified the Director of Nursing Services (DNS) of Resident #3's allegation of verbal abuse on [DATE] and the DNS informed LPN F she would notify the Administrator. Review of Resident #3's FRI revealed the facility submitted an allegation of staff to resident verbal abuse on [DATE] at 1:30 PM to the state agency. Further review revealed the incident occurred on [DATE] at 4:30 AM. The facility failed to report the incident to the state agency within the 2-hour timeframe, there was a delay of 9 hours between the time of the incident was identified and the time the facility reported the incident to the state agency. Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Alzheimer's Disease, Hallucinations, and Delirium. Review of a quarterly MDS assessment dated [DATE], revealed Resident #4's BIMS score showed moderate cognitive impairment. Medical record review revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Dementia, Other Behavioral Disturbance, Anxiety Disorder, and Encounter for Palliative Care. Review of an admission MDS assessment dated [DATE], revealed Resident #22 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the facility investigation dated [DATE], showed the facility submitted a FRI as an allegation of physical abuse to the state agency. The documentation stated staff observed and intervened when Resident #22 had Resident #4's forearms in her hands on [DATE] at 10:32 AM. Further review revealed the date and time of reporting the allegation of physical abuse to the state agency was made on [DATE] at 2:00 PM. The facility failed to report the incident to the state agency within the 2-hour timeframe and there was a delay of 20 hours and 32 minutes between the time the incident was identified and the time the facility reported the incident to state agency. During an interview on [DATE] at 10:40 AM, the DNS confirmed the facility failed to report allegation of physical abuse for Resident 's #4 and #11 to the state agency timely and to the local police. Medical record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Mood Disorder, Anxiety Disorder, and Dementia. Review of an annual MDS assessment dated [DATE], revealed Resident #11 scored a 8 on a BIMS assessment, which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, Heart Failure, and Atrial Fibrillation. Review of a quarterly MDS assessment dated [DATE], revealed Resident #12 scored a 5 on a BIMS assessment which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the FRI dated [DATE], revealed an alleged resident-to-resident altercation between Residents' #11 and #12 occurred on [DATE] at 8:15 PM. Continued review showed the facility reported the altercation to the state agency on [DATE] at 6:00 AM. Further review showed the facility failed to report the incident to the state agency within the 2-hour timeframe and there was a delay of 9 hours and 45 minutes between the time the incident was identified and the time the facility reported the incident to state agency. During an interview on [DATE] at 10:40 AM, the DNS confirmed the facility failed to report the allegation of resident-to-resident physical abuse on [DATE] between Resident #11 and Resident #12 to the state agency timely, within the mandatory 2-hour time frame. During an interview on [DATE] at 4:00 PM, the Administrator confirmed the facility failed to report employee to resident verbal abuse for Resident #1 and Resident #3 and the facility failed to report allegations of resident-to-resident physical abuse that occurred between Resident #4 and Resident #22 to the state agency within the mandatory 2-hour reporting period. During further interview the Administrator stated .I'm responsible . Refer to F600 and F610.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568 Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to ensure thorough investigations were conducted for 1 resident (Resident #13) of 3 residents reviewed for injuries of unknown origin and for 5 residents (Residents #11, #12, #1, #3, and #4 and #22) of 21 residents reviewed for abuse. The findings include: Review of the facility's policy titled, Resident-to-Resident Altercations, dated ,d+[DATE], revealed .All altercations, including those that may represent resident-to-resident abuse, shall be investigated .Identify what happened, including what might have led to aggressive conduct on the part of one or more of the individuals involved in the altercations .Complete a Report of Incident/Accident form and document the incident, findings, and any corrective measures taken in the resident's medical/clinical record . Review of the facility's policy titled, Abuse and Neglect - Clinical Protocol, dated ,d+[DATE], revealed . Assessment and Recognition .The nurse will assess the individual and document related findings. Assessment data will include .Injury assessment (bleeding, bruising deformity, swelling .pain assessment . Current behavior .Patients' age and sex .All current medications .Other platelet inhibitors .Vital signs . Behaviors over last 24 hours .history or tendency towards bruising .all active diagnosis .any recent labs . Review of the facility's policy titled, Accidents and Incidents - Investigating and Reporting, dated ,d+[DATE], revealed .All accidents or incidents involving residents .occurring on our premises shall be investigated .the following data shall be included .Report of Incident/Accident Form .The circumstances surrounding the accident or incident .name(s) of witnesses and their accounts of the accident or incident .Follow-up information . Medical record review revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Dementia, Depression, and Seizures. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #13 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of a Nurse's note for Resident #13 dated [DATE], revealed the resident complained of chest/rib pain and a chest x-ray was order and completed on [DATE]. Review of Resident #13's Chest x-ray report (obtained through the mobile imaging company) dated [DATE], revealed the resident had sustained a left 9th rib fracture. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's investigation for Resident #13 dated [DATE], revealed the facility was unable to determine how or where the resident's injury occurred. There were no noted changes in the resident's behavior related to his injury. The resident did state he had rib/chest pain on [DATE] and informed the nurse. Further review showed the facility had no documentation to indicate staff and resident interviews were conducted after Resident #13's injury of unknown origin was identified on [DATE]. During an interview on [DATE] at 9:25 AM, the Director of Nursing Services (DNS) stated the staff interviews for the injury of unknown origin could not be located and confirmed the injury of unknown origin investigation had not been completed for Resident #13. During an interview on [DATE] at 11:10 AM, the DNS confirmed it was her expectation the facility would conduct interviews with staff and residents, who had a BIMS of 12 or greater, after an identification of injury of unknown origin or any allegation of abuse. Continued interview confirmed there was no documentation of staff interviews in the facility's investigation. The DNS confirmed a thorough investigation was not conducted for Resident #13's injury of unknown origin. Medical record review revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Depression, Mood Disorder, Insomnia, Anxiety Disorder, and Dementia. Review of an annual MDS assessment dated [DATE], revealed Resident #11 scored an 8 on a BIMS assessment which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #12 was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, Heart Failure, Atrial Fibrillation, and Insomnia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #12 scored a 5 on a BIMS assessment which indicated the resident had severe cognitive impairment. Review of the facility investigation for Residents #11 and #12 dated [DATE], revealed a Certified Nursing Assistant (CNA) on [DATE], heard yelling in Resident #11's and #12's room (the residents were roommates) and entered the room. Further review revealed the nurse observed 3 vertical red areas, approximately 2 inches in length and ,d+[DATE] inch wide. Review revealed Resident #11 had no open areas noted on her skin. Resident #11 had a slight red area located on the right upper side of her face. Further review revealed no documentation of resident skin assessments, resident interviews or staff interviews were conducted by the facility and in the facility's investigation. During an interview on [DATE] at 11:10 AM, the DNS confirmed it was her expectation the facility would conduct interviews with staff and residents with a BIMS score of 12 or greater. The DNS confirmed it was her expectation skin assessments would be conducted on all residents with BIMS less than 12 following an allegation of abuse. The DNS confirmed the facility did not conduct a complete and through investigation into the resident-to-resident abuse incident which occurred on [DATE]. Medical record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Senile Degeneration of the Brain, Dementia, and Malignant Neoplasm of the Stomach. Resident #1 expired in the facility on [DATE]. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a quarterly MDS assessment dated [DATE], revealed Resident #1 scored a 9 on a BIMS assessment which indicated the resident had moderate cognitive impairment. Review of the Nurse's progress notes for Resident #1 date [DATE], revealed no documentation to indicate the resident's physician and family were notified. Review of a facility investigation documentation dated [DATE], showed Resident #1 reported to Certified Nurse Assistant (CNA) E she was afraid of CNA D and did not want CNA D to provide care for her. Continued review showed no documentation of physician notification nor notification of family representative. Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Anemia, Unspecified Dementia, and Anxiety. Review of the quarterly MDS assessment dated [DATE], revealed Resident #3 scored 12 on a BIMS assessment which indicated the resident had moderate cognitive impairment. Review of the facility investigation summary of resident interviews conducted on [DATE], revealed Resident #3 reported CNA D was rude and talked down to him. Continued review showed no documentation of physician or family representative notification. During an interview on [DATE] at 11:10 AM, the DNS confirmed the expectation was to notify the residents' physician and family representative after any allegation of abuse. Continued interview confirmed there was no documentation of physician or family representative notification in the investigation documentation for Resident #1 and Resident #3. Medical record review revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Anxiety Disorder, Alzheimer's Disease, Hallucinations, and Delirium. Review of a quarterly MDS assessment dated [DATE], revealed Resident #4 had a BIMS score of 12 which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Dementia, Other Behavioral Disturbance, Anxiety Disorder, and Encounter for Palliative Care. Review of an admission MDS assessment dated [DATE], revealed Resident #22 scored a 6 on BIMS which indicated the resident had severe cognitive impairment. Review of the facility investigation dated [DATE], showed the facility failed to perform skin assessments, and complete staff and resident interviews after an allegation of Resident-to-Resident abuse between Resident #4 and #22. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 11:10 AM, the DNS confirmed the expectation was to conduct interviews with staff, and residents with a BIMS score of 12 or greater and to complete resident skin assessments after an allegation of abuse was identified. Continued interview confirmed there was no documentation of skin assessments or staff /resident interviews included in the facility investigation. The DNS confirmed a thorough investigation was not completed for the allegation of Resident-to-Resident abuse between Resident's #4 and #22. During an interview on [DATE] at 3:50 PM, the Administrator stated .We had issues with incomplete investigations . During an interview on [DATE] at 4:00 PM, the Administrator stated investigations for abuse and injuries of unknown origin were expected to include staff interviews, interviews with residents with BIMS of 13 or greater, and skin sweeps of residents. Further interview revealed .I'm responsible . 35460 40606

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445259	A. Building B. Wing	05/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit View of Rocky Top	204 Industrial Park Rd Rocky Top, TN 37769

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 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** 36003 Based on facility policy review, medical record review, and interviews, the facility failed to revise a comprehensive care plan for 4 residents (Residents #3, #1, #4, and #22) of 21 care plans reviewed following abuse and allegations abuse. The findings include: Review of the facility's policy titled Care Plans, Comprehensive Person-Centered, dated ,d+[DATE] revealed . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change . Review of the facility's policy titled Resident-to-Resident Altercations, dated ,d+[DATE] revealed .If two residents are involved in an altercation, staff will .Make any necessary changes in the care plan approaches to any or all of the involved individuals . Medical record review revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Anemia, Unspecified Dementia, and Anxiety. Medical record review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored 12 on a Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment. Review of the facility's investigation summary of resident interviews dated [DATE] revealed during the facility's investigation of another allegation of abuse, Resident #3 reported CNA D was rude and had talked down to him. Medical record review of a Comprehensive Care Plan for Resident #3 dated [DATE] revealed the care plan had not been revised with a new intervention following an incident of verbal abuse of Resident #3 by CNA D. Medical record review revealed Resident #1 was admitted to the facility on [DATE] and expired on [DATE]. Diagnoses included Senile Degeneration of the Brain, Dementia, and Malignant Neoplasm of the Stomach. Review of a quarterly MDS assessment dated [DATE], revealed Resident #1 scored a 9 on a BIMS assessment which indicated the resident had moderate cognitive impairment. Review of the facility's documentation dated [DATE] revealed Resident #1 reported a Certified Nursing Assistant (CNA) had been rude and threatening toward the resident. Medical record review of a Comprehensive Care Plan for Resident #1 dated [DATE] revealed the care plan had not been revised with a new intervention following an incident of verbal abuse of Resident #1 by CNA D. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Anxiety Disorder, Alzheimer's Disease, Hallucinations, and Delirium. Review of a quarterly MDS assessment dated [DATE], revealed Resident #4 scored a 12 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Medical record review revealed Resident #22 was admitted to the facility on [DATE], with diagnoses including Dementia, Other Behavioral Disturbance, Anxiety Disorder, and Encounter for Palliative Care. Review of an admission MDS assessment dated [DATE], revealed Resident #22 scored a 6 on BIMS assessment which indicated the resident had severe cognitive impairment. Review of the facility investigation documentation dated [DATE], revealed the facility submitted a Facility Reported Incident (FRI) to the state agency regarding a resident-to-resident abuse allegation. The documentation revealed nursing staff observed both of Resident #22's forearms being held by Resident #4 on [DATE]. During an interview on [DATE] at 1:35 PM, the Director of Nursing Services confirmed the comprehensive care plans for Residents #1, #3, #4 and #22 were not revised following allegations of abuse.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. 49786 Based on review of the Quarterly Payroll Based Journal (PBJ) report and interview, the facility failed to report PBJ data for the 3rd and 4th Quarters in 2022 and the 1st and 2nd Quarters in 2023. The findings include: Review of the facility's PBJ report dated 4/1/2022-6/30/2022 (3rd Quarter for 2022) revealed the facility failed to submit the PBJ data. Review of the facility's PBJ report dated 7/1/2022-9/30/2022 (4th Quarter for 2022) revealed the facility failed to submit the PBJ data. Review of the facility's PBJ report dated 10/1/2022-12/31/2022 (1st Quarter for 2023) revealed the facility failed to submit the PBJ data. Review of the facility's PBJ report dated 1/1/2023-3/31/2023 (2nd Quarter for 2023) revealed the facility failed to submit the PBJ data. During an interview on 4/24/2024 at 10:00 AM, the Administrator stated it was his responsibility to submit the PBJ data. The Administrator confirmed he did not submit PBJ data for the 3rd and 4th Quarter of 2022 and the 1st and 2nd Quarter of 2023.