STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, facility documentation review, and interview, the facility failed to provide quarterly financial statements for 5 residents (Residents #8, #27, #28, #34, and #78) with personal fund accounts of 88 residents reviewed with personal fund accounts managed by the facility. The findings include: Review of the facility's undated policy titled, Resident Trust Funds, showed .The resident has a right to manage his or her financial affairs .The individual financial record must be available to the resident through quarterly statements and upon request . Resident #8 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Paranoid Personality Disorder, Schizoaffective Disorder, and Major Depressive Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #8 had moderate cognitive impairment. Review of a Resident Fund Statement for Resident #8 for the period of 12/30/2023 - 3/29/2024, showed an ending balance of $875.80. During an interview on 4/2/2024 at 4:42 PM, Resident #8 stated she had a resident trust account maintained by the facility and did not receive quarterly statements for her account. Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Left Lower Leg Fracture, Osteoarthritis, Abnormalities of Gait and Mobility, Major Depressive Disorder, and Post Traumatic Stress Disorder. Review of a quarterly MDS assessment dated [DATE], showed Resident #27 had moderate cognitive impairment. Review of a Resident Fund Statement for Resident #27 for the period of 12/30/2023 - 3/29/2024, showed an ending balance of $646.71. (continued on next page)

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

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/1/2024 at 10:06 AM, Resident #27 stated she had a resident trust account maintained by the facility and did not receive quarterly statements for her account. During a telephone interview on 4/2/2024 at 4:25 PM, Resident #27's responsible party stated Resident #27 had a resident trust account and she did not receive quarterly trust account statements for Resident #27. Resident #28 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Peripheral Vascular Disease, Major Depressive Disorder, and Chronic Pain Syndrome. Review of a Resident Fund Statement for Resident #28 for the period of 12/30/2023 - 3/29/2024, showed an ending balance of $20.30. Review of a significant change MDS assessment dated [DATE], showed Resident #28 had severe cognitive impairment. During a telephone interview on 4/2/2024 at 3:16 PM, Resident #28's responsible party stated Resident #28 had a resident trust account at the facility and she did not receive quarterly trust account statements for Resident #28. Resident #34 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Schizophrenia, and Osteoarthritis. Review of a Resident Fund Statement for Resident #34 for the period of 12/30/2023 - 3/29/2024, showed an ending balance of $525.03. Review of an annual MDS assessment dated [DATE], showed Resident #34 was cognitively intact. During an interview on 4/1/2024 at 10:41 AM, Resident #34 stated she had a resident trust account maintained at the facility and she did not receive quarterly statements for her resident trust account. Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Mild Neurocognitive Disorder, and Major Depressive Disorder. Review of a Resident Fund Statement Resident #78's for the period of 12/30/2023 - 3/29/2024, showed an ending balance of $28.02. Review of a quarterly MDS assessment dated [DATE], showed Resident #78 was cognitively intact. During an interview on 4/1/2024 at 9:44 AM, Resident #78 stated he had a resident trust account maintained at the facility and he had not received quarterly statements for his resident trust account. (continued on next page)

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/2/2024 at 11:28 AM, the Business Office Manager (BOM) stated she was responsible for resident trust accounts. The BOM stated residents were to receive resident trust statements quarterly. The BOM stated (owner of company that manages Resident Trust statements) previously mailed the quarterly statements to the facility and the BOM then mailed statements to the residents and/or resident representatives. The BOM stated the Company which managed the Resident trusts stopped sending quarterly statements to the facility .close to a year ago . and the BOM did not realize the facility had access to print and send the statements. The BOM confirmed quarterly resident trust account statements had not been sent to residents or resident representatives for .close to a year .

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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, observation, and interview, the facility failed to protect residents from abuse and failed to identify abuse after resident-to-resident altercations for 6 residents (Residents #91, #40, #24, #73, #46 and #44) of 37 residents reviewed for abuse which resulted in injuries. Resident #91, with severe cognitive impairment, actively wandered into other resident rooms, and had no interventions implemented to protect the resident. Resident #40 had severe cognitive impairment and a history of resident-to-resident altercations and aggressive behaviors with no interventions implemented to protect other residents from abuse. Resident #91 sustained injuries of 3 scratches to the left cheek and 1 to the left eyebrow after an altercation between Residents #91 and #40 on 3/30/2024. Residents #73, with severe cognitive impairment, sustained a bruise to the bridge of the nose, and Resident #24, with severe cognitive impairment, sustained an abrasion to the top of the scalp, redness to the face, and a bruise to the bridge of the nose after an altercation on 2/9/2024. Resident #46, with moderate cognitive impairment sustained a scratch to the face and right forearm after an altercation with Resident #44, who had moderate cognitive impairment, on 2/11/2024. The facility's failure to protect residents from abuse and identify resident-to-resident altercations as abuse placed Residents #91, #40, #24, #73, #46, and #44 in an Immediate Jeopardy (IJ) situation, (A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to result in serious injury, harm, impairment, or death to a resident, and must be immediately corrected). The facility's failure to identify resident-to-resident altercations as abuse had the potential to affect all 101 residents in the facility. The Administrator, Director of Nursing, [NAME] President (VP) of Regulatory Compliance and Quality Assurance and Performance Improvement (QAPI) Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-600 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited IJ at F-600 at a scope and severity of K, which constituted Substandard Quality of Care. An Extended survey was conducted onsite from 4/10/2024 - 4/11/2024. The IJ began on 2/9/2024 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. An acceptable removal plan, which removed the immediacy of the jeopardy, was provided by the facility on 4/10/2024 for F-600. Noncompliance continues at F-600 at a scope and severity of E to monitor the effectiveness of the action plan. The corrective actions were validated onsite by the surveyors on 4/11/2024 for F-600. The facility is required to submit a Plan of Correction (POC). (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	The findings include: Review of the facility's policy titled, Abuse Prohibition/Investigative Policy, dated 11/2016, showed .facility will prohibit abuse .to ensure .the facility is doing all .to prevent occurrences of abuse .Administrator is responsible for the implementation of the policies and procedures that prohibit abuse .Abuse; is the willful infliction of injury .with resulting physical harm .Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .Willful .means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Training will be provided to all employees through orientation, annual education, and on-going sessions about: Appropriate interventions to deal with aggressive .residents .What constitutes abuse .Policies and Procedures on Protection, Identification and reporting abuse .Actions to prevent abuse will include .Identifying, correcting and intervening in situations in which abuse .are more likely to occur .Developing a care plan identifying appropriate intervention to prevent occurrences .Staff will be responsible for identifying and reporting occurrences that may constitute events of Abuse .Suspicious bruising, abrasions, lacerations, and any injury of unknown origin. Also .Resident to Resident abuse .Anyone who witnesses an incident of suspected abuse .report it to the nursing supervisor immediately .If the suspected perpetrator is another resident the Director of Nursing [DON] or designee shall separate the resident so that they do not have access to one another until the circumstances surrounding the alleged incident can be determined .All reports of suspected abuse must be reported to the Administrator immediately, as well as the Abuse Coordinator .The state/federal requirements for alleged incidents must be followed .social services director/designee will monitor the resident feelings concerning the incident and document the findings in the resident's medical record . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, showed .Residents have the right to be free from abuse .This includes .physical abuse . program consists of .commitment to support the following objectives .Protect residents from abuse .by anyone including .other residents .Develop and implement policies and protocols to prevent and identify . abuse or mistreatment of residents .caring for all residents .particularly those with behavioral, cognitive or emotional problems .Provide staff .training .that include .topics such as abuse prevention, identification and reporting of abuse .handling .physically aggressive resident behavior .Implement measures to address factors that may lead to abusive situations .Identify and investigate all possible incidents of abuse . (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Unusual Occurrences, showed .Unusual occurrences may include but are not limited to .Resident to resident altercation .Behavior incident that results to injury .The Nurse will .Assess the resident's condition .Notify the charge nurse/nurse manager of the unusual occurrence .Notify DON/Administrator: For any unusual occurrence that may be related .abuse, the facility will follow the abuse policy. The charge nurse will notify the DON/NHA [Nursing Home Administrator] of the unusual occurrence .For resident-to-resident occurrence which does not involve willful action secondary to residents' cognitive impairment and behaviors, the facility will ensure the following are completed .notify the MD/NP [Medical Doctor/Nurse Practitioner] .Complete an incident report .Document the occurrence in the medical records .Document the residents' behaviors and notify the provider .Complete the post-occurrence monitoring .Any further decline or worsening of behavior should be reported to the provider for possible medication regimen review or other behavior management interventions .For resident to resident where there is reasonable suspicion of abuse or crime, the facility will follow the abuse policy. Resident-to-resident altercations that must be reported in accordance with the regulations include any will action that results in serious physical injury, mental anguish, or pain . Resident #91 was admitted to the facility on [DATE] with diagnoses of COVID-19 and Vascular Dementia with Agitation. Review of the admission Minimum Data Set (MDS) assessment for Resident #91 dated 1/11/2024, showed a Brief Interview for Mental Status (BIMS) score of 3, which indicated Resident #91 had severe cognitive impairment. Review of the facility document titled, INTERDISCIPLINARY TEAM (IDT) CARE CONFERENCE NOTE/CARE PLANNING PROCESS, for Resident #91 dated 1/11/2024, showed .admitted to secure unit because of dementia with wandering behaviors .She goes about the unit . Review of the care plan for Resident #91 dated 1/12/2024, showed Resident #91 had .impaired cognitive function/dementia .Administer medications as ordered. Observe/document for side effects and effectiveness . Resident #91 required staff assistance with activities of daily living, and ambulated independent. Review of the care plan for Resident #91 dated 1/20/2024, showed Resident #91 had .Abusive verbal attacks on staff and others . There were no interventions for this focus on Resident #91's care plan. Review of the care plan for Resident #91 dated 1/22/2024, showed Resident #91 had a .Behavior Care Plan . Potential for impaired or inappropriate behaviors related to Dementia .Administer medications as ordered. Observe/document for side effects and effectiveness .Provide program of activities that is of interest and accommodates residents [resident's] status . The resident's care plan does not have an activity problem/program. Continued review showed .Elopement Risk Care Plan . There were no interventions for this focus area on Resident #91's care plan. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nursing Note for Resident #91 dated 3/30/2024 at 3:51 AM, showed .Responded to CNA [Certified Nursing Assistant] #1 reporting that two residents [Resident #91 and #40] were having altercation, upon arrival residents were separated, this resident [Resident #91] being nonaggressive, resident remained calm. resident noted to have four reddened scratch marks, three on the left cheek, and one above the left eyebrow. areas cleaned with NS [normal saline] resident removed away from harm. resident sitting close to the nurses' station at this time, has no complaints of pain or discomfort. NP (Nurse Practitioner), DON, and Family notified . Review of an Incident Report dated 3/30/2024 at 4:00 AM, showed Licensed Practical Nurse (LPN) #2 completed an incident report for an incident involving Resident #91 in the 300 Hall. The Incident Report showed .Responded to CNA reporting that two residents were having altercation, upon arrival residents were separated, this resident being non-aggressive, resident remained calm. resident noted to have four reddened scratch marks, three on the left cheek, one above the left eyebrow. areas cleaned with NS resident removed away from harm. resident sitting close to the nurses [nurses'] station at this time, has no complaints of pain or discomfort. NP, DON, and Family notified .Immediate Action Taken .separated residents, removed resident from harm, assessed resident, cleaned area with NS. Contacted DON, NP, and family .Predisposing Physiological Factors .Confused .Impaired Memory .Predisposing Situation Factors .Wanderer .Witnesses . [CNA #1] . During an observation on 4/1/2024 at 12:14 PM, Resident #91 wandered about the secure unit without redirection or staff assistance. During an observation on 4/1/2024 at 12:30 PM, Resident #91 wandered about the secure unit. Resident #91 was naked from the waist down and held a pair of pants in her hands. (RN) #1 assisted Resident #91 to her room. Resident #91 returned to the hall with pants on and continued to wander about the unit without further redirection or activity offered. During an observation on the secure unit on 4/2/2024 at 2:30 PM, Resident #91 was observed to have a residual red scratch on the left cheek and a dark pink spot above the left eyebrow from the altercation with Resident #40 on 3/30/2024. During an observation on 4/4/2024 at 8:28 AM, Resident #91 wandered in the hall and going in and out of other residents' rooms. Further observation showed nursing staff including LPN #3 seated at the nurses' station and made no attempts to redirect Resident #91 or offer any meaningful activity. During an interview on 4/4/2024 at 8:32 AM, LPN #3 confirmed Resident #91 wandered about the unit, and the intervention to redirect was to give the resident a snack. LPN #3 was unaware of any further interventions for Resident #91's wandering behaviors and stated the resident was difficult to redirect. During an observation on 4/4/2024 at 8:52 AM, Resident #91 walked towards the nurses' station with a package of candy in her hand and a piece of candy in her mouth. RN #1 intervened and took the package of candy away from Resident #91. RN #1 stated the candy belonged to another resident. Resident #91 wandered about the unit. A few moments later, a male resident was heard yelling for help. This surveyor observed Resident #91 standing at the foot of a male resident's bed. LPN #3 entered shortly after and escorted Resident #91 into the hallway, and Resident #91 continued to wander about the unit with no further intervention from LPN #3. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the hospital Discharge Documentation for Resident #40 dated 2/13/2024, showed the resident was hospitalized from 1/26/2024 - 2/13/2024. It was noted .pt [patient] [Resident #40] from [named assisted living facility] involved in alleged altercation with another resident and staff member. hx [history] dementia . Chief Complaint .Dementia, acute mental status change .aggression .History of Present Illness .past medical history of dementia .admitted in Senior Behavioral unit .because of her aggressive behavior and placement . patient is a resident .in memory care unit for the past 1 year and patient's cognition getting worse .and she was aggressive and she got hit on her neck and face and police was called and she was taken to emergency department .Patient's son reports that [named assisted living facility] will not take her back and she will need placement to another safe memory care facility .Patient's son reported she is paranoid and she thinks that somebody is going to kill her. She does get aggressive .Per patients [patient's] attending nurse [at the hospital] .patient has been very combative .The attending nurse reports that 3 nurses [at the hospital] had been hurt by the patient as she has been punching and kicking nursing staff .Attending nurse reports that the patient is not rational and cannot explain her behaviors .Mental Status Exam .Patient is a little bit paranoid, judgment and insight impaired .Patient Discharge Condition .Stable for discharge .Discharge Disposition . Discharge Patient . Resident #40 was admitted to the secure unit at the facility on 2/13/2024 with diagnoses including Dementia with Other Behavioral Disturbance, and Depression. Review of the Abuse Screening Indicator for Resident #40 dated 2/13/2024, showed .Evaluate the resident in each of the FIVE (5) categories listed below. If you answered (Yes) to any of the questions, an abuse care plan should be initiated specific to the resident's risk factors . The category that asked .History of Abuse . (including physical .) .prior to admission . was answered .Undetermined . The category that stated .Factors that increase the residents vulnerability (e.g. [example] dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of being exploited . was answered .YES . The category that stated History or presence of dysfunctional behavior (e.g. [example], provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peers rooms/personal space . was answered .YES . Review of the Screening for Aggressive Behavior for Resident #40 dated 2/13/2024, showed .HISTORY OF ABUSE/NEGLECT EITHER AS A RECEIPIENT OR PERPETRATOR INCLUDING ABUSIVE AND/OR INAPPROPRIATE SEXUAL BEHAVIOR . was marked as a .MODERATE PROBLEM . Review of the admission MDS assessment dated [DATE], showed Resident #40 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan for Resident #40 dated 2/21/2024, showed .Behavior Care Plan .has potential for impaired or inappropriate behaviors related to wandering, refusing medications, disrobing other patients . Administer medications as ordered .Anticipate and meet The resident's needs .Caregivers to provided [provide] opportunity for positive interaction, attention. Stop and talk with him/her as passing by .Explain all procedures to the resident before starting and allow the resident to adjust to changes .Observe for behavior episodes and attempt to determine the underlying cause . Continued review showed .impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia . Further review showed .has a communication problem r/t dementia with behaviors, sometimes understands .Be conscious of resident position when in groups, activities, dining room to promote proper communication with others . Continued review showed .Mood Care Plan .potential for mood state issues related to dementia with behaviors . The care plan did not address Resident #40's aggressive behavior. Review of LPN #2 's Nursing Note for Resident #40 dated 3/7/2024 at 4:50 AM, showed .[Resident #40] showing increasing s/s [signs and symptoms] of agitation, with other residents, and staff called NP with new orders for Geodon [antipsychotic medication] 10mg [milligrams] via [by way of] IM [intramuscular] injection one time only .contacted POA [Power of Attorney] .tolerated injection well . Review of the Progress Note for Resident #40 dated 3/7/2024, showed Chief Complaint/Nature of Presenting Problem: Behavior follow up .I am seeing her today to follow up on agitation early this am .unable to be redirected .gave her an injection of geodon .she calmed down and went to sleep .Plan .continue reminiscence therapy and cognitive stimulation .address any behavioral related issues that may come up . Review of Licensed Clinical Social Worker's (LCSW) Progress Note for Resident #40 dated 3/8/2024, showed .Chief Complaint/Nature of Presenting Problem: Behavior follow up .I [LCSW] am seeing her today to follow up on aggitation [agitation] last night she was going from room to room taking other patient's items and nursing had a hard time getting her redirected .Diagnosis, Assessment and Plan .Moderate dementia with agitation .Adjustment disorder with anxiety .increase nighttime dose of Risperdal [antipsychotic medication] .and monitor behaviors . Review of LPN #2's Behavior Note for Resident #40 dated 3/30/2024 at 4:31 AM, showed .Responded to CNA reporting that two residents were having altercation, upon arrival residents were separated, this resident [Resident #40] noted to be being aggressive with another resident, resident noted to have scratched another resident [Resident #91] in the face. separated, and redirected resident to residents [resident's] room. Resident [Resident #91] resting in bed at this time .NP, DON, and family aware . Review of Registered Nurse (RN) #7's Nursing Note for Resident #40 dated 3/31/2024, by showed .Resident up wandering in and out of other residents [residents'] room. Taking other residents [residents'] clothes and wearing them. Resident becomes agitated and combative when attempting to retrieve the other resident's items. Resident finally settled down in her own bed after taking her evening medications . During an observation on 4/1/2024 at 10:10 AM, in Resident #40's room, showed the resident pleasant at first, then became agitated, and stood in the doorway blocking this surveyor's ability to exit the room. Resident #40 lifted her arm in preparation to hit the surveyor and a staff member assisted Resident #40 to step out of the doorway to allow this surveyor to exit the room. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/2/2024 at 2:46 PM, RN #1 (the secure unit supervisor) stated Resident #91 wandered about the unit. Resident #91 wandered into other resident's rooms and handled their personal belongings, and made the other residents angry. RN #1 stated the staff tried to redirect the resident, but it was hard to keep her busy. RN #1 stated she was unaware if Resident #91 had any activity interventions to address the wandering behaviors. RN #1 stated there was an incident report in her office about an altercation on 3/30/2024 between Resident #40 and Resident #91. RN #1 stated she was unaware of Resident #91 having injuries, then stated Resident #91 .might have some scratches on her face . RN #1 was unable to give any details about the altercation between Residents #91 and #40 that occurred on 3/30/2024. During continued interview, RN #1 stated the incident report regarding the altercation should have been discussed in the morning meeting on 4/1/2024, but the meeting was cancelled due to the appearance of the state surveyors. RN #1 was unaware when the incident report would be discussed. During an interview on 4/2/2024 at 3:41 PM, the DON stated she was made aware of the altercation between Residents #91 and #40 via text message on 3/30/2024 around 4:00 AM from LPN #2. The DON stated the text message stated Resident #91 had scratches on her face from another resident. The DON confirmed Resident #91 was injured during the altercation and no new interventions were put in place to protect Resident #91 from further injury. The DON stated the corporate people told them a resident-to-resident altercation between residents with low BIMS scores was not considered abuse, because residents with low BIMS scores were not capable of a willful action. During a telephone interview on 4/3/2024 at 10:45 AM, LPN #2 stated she was the nurse on the secure unit during the altercation between Residents #40 and #91 on 3/30/2024. CNA #1 called for help and tried to separate the residents outside Resident #40's room. LPN #2 stated she went to assist CNA #1 and stated Resident #40 had a grasp of Resident #91's hair and arm, and CNA #1 was trying to separate the residents. LPN #2 and CNA #1 separated the residents and Resident #91 was observed to have scratches on her face, the scratches were bleeding, and required first aid. LPN #2 stated she completed an incident report and sent text messages to the DON, NP #1, and the resident's families regarding the incident. LPN #2 stated Resident #40 had been in another incident .early last month . During a second interview on 4/3/2024 at 3:03 PM, LPN #2 stated on 3/7/2024 Resident #40 became very agitated. The resident hit the staff and the staff were unable to redirect the behavior with non-medication interventions. LPN #2 stated NP #1 was called and an order for Geodon 10mg IM was received. During a telephone interview on 4/4/2024 at 2:35 PM, CNA #3 stated on 3/7/2024 she was called by CNA #4 between 2:00 and 3:00 AM to help in Resident #40's room. CNA #3 stated Resident #40 was very agitated and would not calm down. Prior to the episode of agitation Resident #40 had been calm and pleasant. CNA #3 stated Resident #40 was aggressive and hitting at the staff. During a telephone interview on 4/4/2024 at 2:45 PM, CNA #1 stated on 3/30/2024 between 2:00 and 3:00 AM, Resident #91 wandered into Resident #40's room. CNA #1 stated she went down the hall towards Resident #40's room and observed the 2 residents outside Resident #40's room. Resident #40 had a hold of #91 by the hair and arm. CNA #1 and LPN #2 separated the 2 residents. Resident #91 had 3 scratches on the left cheek and 1 scratch above the left eyebrow that were bleeding. LPN #2 guided Resident #91 to her room and administered first aid to the scratches. Resident #40 ambulated independently to her room. CNA #1 stated the protocol was to report incidents to the supervisor. CNA #1 stated she provided a written statement about the altercation to LPN #2. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/4/2024 at 3:17 PM, CNA #4 stated on 3/7/2024 she was doing rounds on the 300 back hall in the secure unit and found Resident #40 in her room and very agitated. CNA #4 stated Resident #40 was not redirectable with non-medication approaches. CNA #4 stated Resident #40 was striking out at CNA #4 and CNA #3. LPN #2 also witnessed the resident's agitation. CNA #4 stated LPN #2 called NP #1 to update and get a medication order to help calm the resident down. During an interview on 4/5/2024 at 4:19 PM, the DON and Administrator stated there was an altercation between Resident #91 and Resident #40 on 3/30/2024. Resident #91 entered Resident #40's room. Resident #40 wanted Resident #91 to leave the room and scratched her. Resident #40 had a history of resident-to-resident altercations prior to coming to the facility. The DON was aware that Resident #40 was aggressive with other residents prior to admission and the intervention to protect other residents was to monitor the resident to see how she was with the other residents. The DON confirmed there were no other interventions in place to address Resident #40's history of aggressive behaviors and Resident #40's care plan did not include her history of being aggressive with other residents. The DON stated nurses and CNAs were told verbally about Resident #40's history of aggressive behavior with other residents. The DON stated she was unaware of the episode where Resident #40 became agitated and aggressive with staff and required a Geodon injection on 3/7/2024. The DON stated she was made aware of the altercation between Residents #40 and #91 on 3/30/2024 at around 4:00 AM. The DON confirmed an investigation was not started for the resident-to-resident altercation. The DON made the Administrator aware of the incident later in the morning on 3/30/2024. The Administrator reviewed her call log during this interview and confirmed the DON called her to notify her of the resident-to-resident altercation on 3/30/2024 at 7:36 AM. The Administrator stated she did not remember the contents of the conversation and stated her impression was that Resident #91 wandered into .another resident's room . and it resulted in a scratch to Resident #91's face. The DON confirmed she did not see the altercation as abuse, and the incident was not investigated or reported. The DON confirmed Resident #91 was harmed during the altercation and had scratches to her face. Resident #91 had dementia and wandered all around the unit. The DON stated it was her expectation that there was a person-centered care plan for residents with wandering behaviors and dementia to address behaviors. During an interview on 4/6/2024 at 10:40 AM, NP #1 stated she was notified of the resident-to-resident altercation between Resident #91 and Resident #40. NP #1 stated the scratches Resident #91 received on the left cheek and eyebrow were injuries. NP #1 stated Resident #91 wandered about the unit and the resident's wandering behaviors made the resident vulnerable and at risk for potential harm. During an interview on 4/6/2024 at 11:15 AM, the DON confirmed there were no interventions on Resident #91's care plan to address the resident's wandering behaviors and going into other resident rooms. The DON stated she considered open bleeding scratches to be an injury, and she considered Resident #91's scratches from the resident-to-resident altercation on 3/30/2024 to be an injury. 41782 Resident #24 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Alzheimer's Disease, Dementia, Abnormalities of Gait and Mobility, and Muscle Weakness. Review of the comprehensive care plan for Resident #24 dated 8/22/2016, last revised on 4/23/2021, showed .I have impaired cognitive function r/t Dementia . Resident #24's care plan was not updated to reflect the resident to resident altercation on 2/9/2024. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE], showed Resident #24 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #24 exhibited no behavioral symptoms. Review of the SKIN- Head to Toe Weekly Skin Checks for Resident #24 dated 2/8/2024, showed the resident had no areas of skin impairment. Review of the Nursing Note for Resident #24 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident and the other resident [Resident #76] residing in the room. Assisted by the CNA the nurse was able to deescalate the situation. The resident was separated and assessed for injury. The resident [Resident #24] was noted to have small abrasion to top of scalp, fading redness on face, and bruise at the bridge of nose where glasses rest. Vitals WNL [Within Normal Limits]. DON notified, NP and [NAME] [Niece] .notified of situation. 15-minute safety checks initiated for next 24 hours .Resident received room change . Review of the Room Change Notification note for Resident #24 dated 2/9/2024 at 7:30 PM, showed . Resident Representative Notified via: Phone . Review of the facility document titled, RESIDENT SAFETY CHECK, for Resident #24 dated 2/9/2024, showed .Check Every .15 Minute Check .Safety Concerns .Behaviors/Mood .Altercation [with] Resident . Continued review showed every 15-minute safety checks started at 7:30 PM on 2/9/2024 and ended on 2/10/2024 at 7:45 PM. Review of the Skin observation progress note for Resident #24 dated 2/10/2024 at 4:37 AM, showed . Resident has a new skin impairment .Top of Scalp-skin abrasion .bruising to bridge of nose, and upper right forehead. Responsible party notified . During an observation and interview on 4/6/2024 at 8:30 AM, Resident #24 was seated in the wheelchair beside his bed organizing his socks in his bedside drawer. Resident #24 denied any altercations with other residents. Resident #73 was admitted to facility on 11/23/2022 and readmitted on [DATE] with diagnoses including Right Femur Fracture, Dementia, Abnormalities of Gait and Mobility, Lack of Coordination, and Unspecified Symptoms and Signs Involving Cognitive Functions and Awareness. Review of the care plan for Resident #73 dated 12/2/2022, showed .impaired cognitive function/dementia or impaired thought processes r/t Dementia .communication problem r/t usually understands and usually makes self understood .ADL [activities of daily living] Care Plan .self-care performance deficit r/t weakness . Interventions .requires x[times]1 staff to turn .reposition in bed .toileting .assistance needed with transfers . Resident #73's care plan did not reflect the resident to resident altercation on 2/9/2024. Review of the annual MDS assessment dated [DATE], showed Resident #73 had a BIMS score of 4, which indicated the resident had severe cognitive impairment and required substantial/maximal assistance with chair/bed transfers. Resident #73 exhibited no behavioral symptoms. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the SKIN- Head to Toe Weekly Skin Checks for Resident #73 dated 2/8/2024, showed the resident had a surgical wound to the right hip, excoriation to the buttocks, a blister to the left foot, stage 2 pressure wound, and a left elbow skin tear. No other skin impairments were noted. Review of the Nursing Note for Resident #73 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident and the other resident [Resident #24] residing in the room. Assisted by the CNA the nurse was able to deescalate the situation. The other resident was removed from room, and this resident was assessed for injury. The resident was noted to have a small bruise at the bridge of the nose where glasses rest. Vitals WNL. DON notified, NP, and POA .notified of situation. 15-minute safety checks initiated for the next 24 hours. Residents' roommate received room change. Resident calm and ready to go to sleep. Bed locked and in lowest position, call light and fluid in reach . Review of the facility document titled, RESIDENT SAFETY CHECK, for Resident #73 dated 2/9/2024, showed .Check Every .15 Minute Check .Safety Concerns .Behaviors/Mood .Altercation with Resident . Continued review showed every 15-minute checks were started on 2/9/2024 at 7:30 PM and ended on 2/10/2024 at 7:45 PM. Review of the SKIN- Head to Toe Weekly Skin Checks for Resident #73 dated 2/10/2024, showed the resident had new skin impairment and it was noted .Site .Face .Description .Bruising to bridge of nose . During an observation and interview on 4/6/2024 at [TRUNCATED]

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety 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** 41291 Based on facility policy review, medical record review, and interview, the facility failed to report an injury of unknown origin and resident to resident abuse to the local and state designated authority agencies for 7 of 37 (Residents #39, #24, #73, #46, #44, #91, and #40) sampled residents reviewed for abuse. Resident #39, a vulnerable and severely cognitively impaired, non-ambulatory resident, with bilateral leg contractures, sustained a left femur fracture with an undetermined cause. On 12/20/2023, Resident #39 verbalized increased pain and staff observed swelling in her right lower leg. She was sent to the emergency room (ER) and radiology tests identified a left femur fracture on 12/21/2023. Facility documentation identified right leg pain and swelling, but there was no documentation of left leg pain or swelling in the facility's medical record. The facility failed to complete a thorough investigation into Resident #39's injury of unknown origin. On 2/9/2024, Staff observed Resident #24 and Resident #73, both vulnerable and severely cognitively impaired residents who were roommates, slapping each other in the residents' room. Resident #73 sustained a bruise to the bridge of the nose when the altercation occurred, and Resident #24 sustained an abrasion on top of the scalp, redness to the face, and a bruise to the bridge of the nose. On 2/11/2024 Resident #46, a vulnerable and moderately impaired resident with a history of hallucinations, sustained a scratch to the face and right forearm after an altercation with Resident #44, when he attempted to enter Resident #44's room, who was also moderately cognitively impaired. On 3/30/2024, staff observed Resident #40, a vulnerable and severely cognitively impaired resident with a known history of agitation, combativeness, and abusive and aggressive behaviors, in an altercation with Resident #91. Resident #91, a vulnerable and severely cognitively impaired resident with known aggressive behaviors, sustained 3 scratch marks to the left cheek and 1 scratch mark to the left eyebrow during the altercation with Resident #40. Resident #91's injuries were open, bleeding, and required first aid. The facility's failure to identify and investigate potential abuse resulted in a failure to investigate abuse allegations and an injury of unknown origin which placed Residents #39, #24, #73, #46, #44, #91, and #40 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure to investigate resident-to-resident altercations and an injury of unknown origin had the potential to impact all 101 residents in the facility. The Administrator, Director of Nursing (DON), [NAME] President (VP) of Regulatory Compliance and QAPI (Quality Assurance and Performance Improvement) Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-609 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited Immediate Jeopardy at F-609 at a scope and severity of K which constituted Substandard Quality of Care. An Extended survey was conducted onsite from 4/10/2024 and 4/11/2024. The IJ began on 12/21/2023 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/10/2024 for F-609. Noncompliance continues at F-609 at a scope and severity of E for the monitoring of the effectiveness of the action plan. The corrective actions were validated on site by the surveyor on 4/11/2024 for F-609. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility's policy titled, Abuse Prohibition/Investigative Policy, revised on 11/2016, showed . facility will prohibit abuse .will be completed for all residents through .Reporting of incidents, investigations, and facility response to the results of their investigations .The Administrator is responsible for implementation of the policies and procedures that prohibit abuse .Prevention .Staff will be responsible for identifying and reporting occurrences that may constitute events of Abuse .examples .Suspicious bruising, abrasions, lacerations, and any injury of unknown origin .Also included are events of Resident to Resident abuse .All reports of suspected abuse must be reported to the Administrator immediately, as well as the Abuse Coordinator .The state/federal reporting requirements for alleged incidents must be followed .Upon receiving information concerning an allegation of abuse .the Administrator/Designee will .Notify the Complaint Administration Unit 'As soon as possible' but no later than 24 hours of learning of the allegation .The Administrator will report findings of all completed investigations per state requirements .Notifications: Law Enforcement, Complaint Administration unit (CAU) .The Administrator/Designee will .report all incidents of abuse to the QA [Quality Assessment] & [and] A [Assurance] Committee . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised on 4/2021, showed .Residents have the right to be free from abuse .includes .physical abuse .Protect residents from abuse .by anyone including .facility staff .other residents .any other individual .Develop and implement policies and protocols to prevent and identify .abuse or mistreatment of residents .Provide staff orientation and training .that include topics such as abuse prevention, identification and reporting of abuse . report any allegations within timeframes required by federal requirements .Protect residents from any further harm .implement a QAPI review and analysis of reports, allegations or findings of abuse . Review of the facility's undated policy titled, Unusual Occurrences, showed .Unusual occurrences may include .Resident to resident altercation .The Nurse will .Notify the DON [Director of Nursing]/Administrator: For any unusual occurrence that may be related to .abuse, the facility will follow the abuse abuse .For resident-to-resident occurrence where there is a reasonable suspicion of abuse .the facility will follow the abuse policy. Resident-to-resident altercations that must be reported in accordance with the regulations include any willful action that results in serious physical injury, mental anguish, or pain . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Injury of Unknown Source, showed .This policy will provide guidelines related to unexplainable injuries .Any observed unexplained injuries shall be reported to the resident's nurse .The attending physician/Nurse practitioner notification will be completed .if the injury is of unknown source, reporting .procedures shall be implemented in accordance with the facility's abuse policy and procedures .An injury should be classified as an 'injury of unknown source' when .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of .the extent of the injury . Resident #39 was admitted to the facility on [DATE] with diagnoses including Dementia, Abnormal Gait and Mobility, and Maltreatment. Review of the History and Physical for Resident #39 dated 5/31/2022, showed Resident #39 was non ambulatory and unable to sit in a wheelchair due to leg (bilateral) contractures (a permanent tightening of the muscles, tendons, skin, and surrounding tissues that causes the joints to shorten and stiffen). Review of the quarterly MDS assessment dated [DATE], showed Resident #39 had a BIMS score of 7, which indicated the resident had severe cognitive impairment. Resident #39 required substantial/maximal assistance with mobility. Review of a witness statement dated 12/11/2023, showed Certified Nursing Assistant (CNA) #5 wrote and signed .went to get [Resident #39] out of bed to the shower chair, we could not lift her so we gently lowered her to the ground and got assistance right away to get her into the shower chair when we went back in after the shower the nurse assisted with getting the resident back to her bed . Review of a witness statement dated 12/11/2023, showed Nursing Assistant (NA) #1 wrote and signed .went to get [Resident #39] out of bed to the shower chair, we could not lift her so we gently lowered her to the ground and got assistance right away to get her into the shower chair. When the nurse came in to assist the Resident stated to the nurse that she was not dropped. When we went back in after the shower, the nurse assisted with getting the Resident back to her bed . Review of the facility document titled, SBAR (Situation, Background, Assessment, Recommendation- a verbal or written communication tool that helps provide essential, concise information) Communication, note for Resident #39 dated 12/20/2023, written by Licensed Practical Nurse (LPN) #6 showed .calling about: Right leg pain and swelling .pitting edema [Right] foot .started on 12/20/2023 .Since .started .has stayed the same .Orders received for Emergency Transfer .contact person notified .Care Clinician notified .NP [Nurse Practitioner]. Review of the nursing progress note for Resident #39 dated 12/20/2023, showed .CNA [unknown] reported to nurse [LPN #6] .resident .verbalizing pain upon movement in bed .requesting to go to ER [emergency room]. Resident assessed .Alert and Orientated x [times] 3 [oriented to person, place, and time]. Bilateral chest expansion noted. Skin turgor [the elasticity of the skin] good. Abdomen soft and non distended. Resident verbalizing pain in right leg .leg .swollen to up to right hip .+ [plus] 2 pitting edema in Right foot . Bilateral pedal pulses are noted .Capillary refill isWNL [is within normal limits] bilateral. Resident vocalizes pain to touch BLE [bilateral lower extremities]. Vitals are WNL DON notified. Awaiting EMS [emergency medical service] for transport to ER . (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a witness statement dated 12/20/2023, showed LPN #6 wrote and signed .CNA notified .resident was vocalizing pain with movement. I assessed resident [Resident #39] at this time. Bed was in lowest position and locked. HOB [head of bed] elevated .Resident's right leg is swollen to [right] hip. +2 pitting edema is noted [right] foot. Pedal pulses are present .No bruising noted at this time. Contacted DON. Resident requesting to go to ER. Resident transferred by .EMS . Review of a witness statement dated 12/20/2023, showed RN #5 wrote and signed .asked by .LPN [LPN #6] . to come and visualize the residents [Resident #39] leg .visulized [visualized] swelling of [right] lower extremity, with 2+ pitting edema in [right] foot. The Resident verbalized pain to movement and tactical stimuli. Pedal pulses present .Resident in good spirits .smiling when no movement or stimuli occurring . Review of a witness statement dated 12/20/2023, showed CNA #13 wrote and signed .was assisting another aide in changing [Resident #39], when she started complaining of severe leg pain and hip pain .Her [Resident #39] right leg looked swollen and was warm to the touch. Alerted nurse . Review of the hospital History and Physical for Resident #39 dated 12/21/2023, showed Resident #39 presented to the hospital with .ongoing left knee pain .reports 2 weeks ago, nursing home staff were transferring her to the shower when they accidentally dropped her .has had .pain in her left knee .also has had pain .in .left ankle/foot and .right knee . (the nursing home records indicated Resident #39 had right leg pain and swelling-no mention of left leg pain or swelling). Review of the hospital radiology report for Resident #39 dated 12/21/2023, showed Resident #39 had Osteopenia with a Left Femur Fracture. Review of the Orthopedic Consult Note for Resident #39 dated 12/21/2023, showed upon physical examination the left distal femur had soft tissue swelling with tenderness to the left distal femur region. The case was reviewed and discussed with consideration of Resident #39's comorbidities; .may consider speaking with guardian of the possibility and benefit of above the knee amputation. The likelihood of the fracture healing is low . Review of Resident #39's medical record did not show an incident report or thorough investigation had been completed for Resident #39's left femur fracture. During a telephone interview on 4/3/2024 at 8:10 PM, LPN #6 stated she was the nurse who sent Resident #39 out to the hospital on 12/20/2023, when the resident complained of right leg pain and swelling. LPN #6 notified NP #1 and the DON on 12/20/2023 about the right leg pain and swelling. Orders were received to send Resident #39 to the ER for evaluation and treatment. During an interview on 4/4/2024 at 4:50 PM, the DON stated Resident #39's fracture was brought to her attention on 12/21/2023, after being sent to the hospital and x-rays confirmed the left femur fracture. There was no incident report and staff interviews were all that was obtained for investigation. The DON stated the incident was not a reportable event. When the DON was asked if the incident met the definition of an injury of unknown origin; she stated, I didn't think about that. The DON confirmed neither a formal investigation nor a root cause analysis was conducted. The DON confirmed an incident report was not completed and a thorough investigation to determine the root cause of the fracture was not completed. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/5/2024 at 10:55 AM, the Administrator stated she was aware Resident #39 had been sent to the hospital and identified with a fracture on 12/21/2023. Staff interviews were conducted by the DON after she and the DON were notified of Resident #39's fracture. The Administrator stated a root cause analysis meeting was not held and her determination of the root cause of the fracture was solely based off staff interviews. The Administrator stated she was .the abuse coordinator for the facility . and there was no discussion that Resident #39's fracture could have possibly been identified as an injury of unknown origin. The Administrator said she was aware serious physical harm was reportable within 2 hours based on regulatory agencies and she was able to make the determination within 2 hours of being made aware of Resident #39's fracture, the cause of the injury from staff interviews. The Administrator confirmed the facility did not follow their policies for identifying, investigating, and reporting injuries of unknown origin. 41782 Resident #24 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Alzheimer's Disease, Dementia, Abnormalities of Gait and Mobility, and Muscle Weakness. Review of the comprehensive care plan dated 8/22/2016, last revised on 4/23/2021, showed Resident #24 .I have impaired cognitive function r/t Dementia . Resident #24's care plan was not updated to reflect the resident to resident altercation on 2/9/2024. Review of the quarterly MDS assessment dated [DATE], showed Resident #24 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #24 exhibited no behavioral symptoms. Review of the Nursing Note for Resident #24 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident and the other resident [Resident #73] residing in the room. Assisted by the CNA [Certified Nursing Assistant] the nurse was able to deescalate the situation. The resident was separated and assessed for injury. The resident was noted to have small abrasion to top of scalp, fading redness on face, and bruise at the bridge of nose where glasses rest. Vitals WNL [Within Normal Limits]. DON notified, NP, and [NAME] [Niece] .notified of situation. 15-minute safety checks initiated for next 24 hours .Resident received room change: Resident now residing in 223A. Roommate in agreement. Resident oriented to new room, call light and bed control. Bed locked and in lowest position call light in reach . Review of the facility document titled, RESIDENT SAFETY CHECK, for Resident #24 dated 2/9/2024, showed staff completed safety checks on Resident #24 every 15 minutes from 7:30 PM until 7:45 PM on 2/10/2024. Resident #73 was admitted to facility on 11/23/2022 and readmitted on [DATE] with diagnoses including Right Femur Fracture, Dementia, Abnormalities of Gait and Mobility, Lack of Coordination, and Unspecified Symptoms and Signs Involving Cognitive Functions and Awareness. Review of the comprehensive care plan dated 12/2/2022, showed Resident #73 .impaired cognitive function/dementia or impaired thought processes r/t Dementia .communication problem r/t usually understands and usually makes self understood, dementia . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the annual MDS assessment dated [DATE], showed Resident #73 had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Resident #73 exhibited no behavioral symptoms. Review of the Nursing Note for Resident #73 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident and the other resident [Resident #24] residing in the room. Assisted by the CNA the nurse was able to deescalate the situation. The other resident was removed from room, and this resident was assessed for injury. The resident was noted to have a small bruise at the bridge of the nose where glasses rest. Vitals WNL [within normal limits]. DON notified, NP, and POA [Power of Attorney] .notified of situation. 15-minute safety checks initiated for the next 24 hours. Residents' roommate received room change. Resident calm and ready to go to sleep. Bed locked and in lowest position, call light and fluid in reach . Review of the facility document titled, RESIDENT SAFETY CHECK, for Resident #73 dated 2/9/2024, showed every 15-minute safety checks were started on 2/9/2024 at 7:30 PM and ended on 2/10/2024 at 7:45 PM for concerns with mood and behaviors after a resident to resident altercation. Review of the facility document titled, SEC [Significant Event Call] WORKSHEET, dated 2/9/2024 at 8:30 PM, showed the altercation with Resident #24 and #73 was discussed. It was noted Resident #73 had a BIMS score of 4 and Resident #24 had a BIMS score of 3 and both residents had a diagnosis of Dementia. Continued review showed Status of investigation Responsibility assigned to: DON/NHA [Nursing Home Administrator] .Is it reportable .No .Notified Entities .DOH [Department of Health] .No Family: Date notified . 2/9/24 .MD: Date notified .2/9/24 .Root Cause analysis .Dementia/Cognition .per SEC call .Status of resident . Safe .If altercation .Resident(s) on 1:1 or on 15-minute checks .Immediate Ad-Hoc [meeting held for a particular or specific purpose] QAPI meeting .2/12/24 [2024] .4:30 pm .Staff de-escalated [and] separated appropriately /POC [Plan of Care] not needed .RECOMMENDATIONS from call .15 min check for 24 hrs . Room change .DON initiated . Review of facility documentation showed attendees on the SEC call dated 2/9/2024, Resident #24 and #73's altercation was discussed amongst the Administrator, DON, Director of Resident Advocate Program, [NAME] President (VP) of Operations, VP of Regulatory Compliance and QAPI Program Consultant, Chief Regulatory and Compliance Officer, and the VP of Clinical Services. During an interview on 4/5/2024 at 12:20 PM, the Administrator stated she was the facility's Abuse Coordinator and was responsible for reporting resident to resident altercations, injuries of unknown source, and abuse to the local and state designated agencies. Resident to resident altercations were discussed on SEC calls with members of the governing body present to determine if the altercation was reportable. Continued interview revealed if a resident's cognition was poor/low, resident to resident altercations were not recognized as abuse but as behaviors. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/5/2024 at 7:32 PM, RN #5 stated she was assigned to provide care for Residents #24 and #73 on the night of the altercation (2/9/2024). RN #5 was at the nurses' station and heard a noise that startled her. The RN immediately went down the hallway to investigate the noise and determined the noise was coming from Resident #24 and #73's room. RN #5 entered the room and observed Resident #24 seated in a chair next to Resident #73's bed and closet and Resident #73 was in his bed leaning over the side. The RN stated Resident #24 was .getting in . Resident #73's closet and the residents were .open hand slapping each other . The RN stated Resident #24 was trying to remove clothes from Resident #73's closet. The RN stated she and an unknown (CNA) separated the residents and Resident #24 was removed from the room to de-escalate the situation. Resident #73 had a small bruise on the bridge of his nose that was gone the next night. Resident #24 had a small bruise on the bridge of his nose where his glasses were, a small abrasion on the top of his head, and scattered redness on his face that faded within a few hours. RN #5 stated Resident #73's speech was hard to understand but the resident was able to tell her .he's in my stuff .get him out of my room . and Resident #24 said .this is my stuff . RN #5 notified the DON via phone immediately of the incident. During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2024 at 10:58 AM, the DON stated RN #5 notified her via telephone that Resident #24 had gotten into Resident #73's closet and Resident #73 hit Resident #24 on top of the head. The residents were roommate at the time of the incident. RN #5 observed the altercation between the 2 residents and the DON confirmed both residents were injured because of the altercation. The DON notified the Administrator immediately, an SEC was conducted with .corporate . on 2/9/2024 at 8:30 PM to discuss the resident to resident altercation, it was determined it did not meet the definition of abuse due the resident's cognition and was not a reportable incident. The DON confirmed the resident-to-resident altercation was not reported to the state agency, local law enforcement, or Adult Protective Services (APS) due to both residents having poor cognition with low BIMS scores and could not have acted willfully. This surveyor reviewed the facility's Abuse Prohibition/Investigative Policy with the DON. The DON stated according to the facility's policy the definition of abuse is .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 .includes physical abuse .willful .means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . The DON confirmed the residents hitting each other over Resident #24 getting in Resident #73's closet was willful and deliberate with resulting physical injuries; and further confirmed the resident to resident altercation should have been considered abuse and reported to the state agency, local law enforcement, and APS. The DON confirmed the facility's abuse policy was not followed for the resident to resident altercation between Residents #24 and #73. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2023 at 12:33 PM, the Administrator stated RN #5 witnessed an altercation between Residents #24 and #73 on 2/9/2023; .From my recollection ., the residents were roommates and had a physical altercation about one being in the other's closet and they were separated . The Administrator was made aware of the altercation by the DON but was unable to recall the date or time. Upon review of the nursing documentation provided to this surveyor regarding the altercation, the Administrator confirmed both residents sustained injuries from the altercation. The Administrator stated the altercation was discussed with members of the governing body present to determine if the altercation was a reportable event. The Administrator stated the governing body on the SEC call determines if the altercation should be reported to the local and state designated agencies. During the call, it was determined that the root cause was the residents' .dementia, cognition status, and conflicting personalities . and was not a reportable event. Continued interview with the Administrator confirmed the resident to resident altercation was not identified as abuse; .we identified it as a behavior .not abuse . She also confirmed the facility did not follow it's policy for abuse investigations; .The Resident Abuse Investigation Report form and The Abuse Log were not completed .the incident was not reported to the state agency, law enforcement, or APS . The Administrator added it was her expectation for federal regulations to be followed. During an interview on 4/8/2024 at 12:03 PM, the Administrator stated the facility followed the Unusual Occurrences policy for the resident-to-resident altercation with Residents #24 and #73. The Unusual Occurrences policy states that resident-to-resident occurrences that do not involve willful action secondary to residents' cognitive impairment and behaviors are not considered abuse. Resident to resident altercations that include willful action that results in physical injury must follow the abuse policy and be reported to the state agency, law enforcement, and Adult Protective Services (APS). The SEC call regarding Residents #24 and #73's altercation determined that Residents #24 and #73 could not have acted willfully due to their cognition and did not have to be reported. During an interview on 4/8/2024 at 12:20 PM, the VP of Regulatory Compliance and QAPI Program Consultant, stated resident-to-resident altercations were to be discussed on SEC calls. The Administrator and DON filled out the SEC Worksheet prior to the call and investigated the altercation. The members of the SEC called and asked the DON and Administrator if the altercation was reportable to the state designated authorities or not a reportable event. The VP of Regulatory Compliance and QAPI Program Consultant confirmed she was on the SEC call to discuss the altercation between Residents #24 and #73 on 2/9/2024. The DON and the Administrator felt there was no willful intent during the altercation with Residents #24 and #73 because of the residents' BIMS scores. The VP of Regulatory Compliance and QAPI Program Consultant stated .I just remember the nurse witnessed an interaction between the residents .we were not provided the information of what the resident altercation was about . It was not presented to the members of the SEC call that one resident was in the other resident's closet at the time of the incident. The VP of Regulatory Compliance and QAPI Program Consultant stated if the DON and Administrator had stated what the altercation was about, .we would have determined that it was a willful act . and the resident to resident altercation should have been reported to the local and state designated authorities. She further confirmed the facility failed to do a thorough investigation on the resident to resident altercation between Residents #24 and #73 and a .BIMS status alone can not determine if an act is willful or not . She also confirmed .all resident to resident altercations should be investigated as potential abuse . 45837 (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #46 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus, Dementia, With Psychotic Disturbance and Anxiety Disorder. Review of an annual MDS assessment dated [DATE], showed Resident #46 had a BIMS of 11, which indicated the resident had moderate cognitive impairment. Review of the care plan dated 4/13/2023, showed Resident #46 .has hallucinations .will state that .see my dead wife .will state that I know the staff or others can see her . Review of a Progress Note for Resident #46, dated 2/12/2024 at 8:58 AM, showed NP #1 saw the resident (Resident #46) after a resident-to-resident altercation. It was noted .Chief Complaint/Nature of Problem: Abrasion left eye and right forearm .advanced dementia and psychosis .He often has delusions of seeing his dead wife and sometimes searches forher [for her]. Last p.m. [PM] he was coming down the hallway and attempting to go into another resident's room because he missed to get for a common area. When the other resident [Resident #44] who also has dementia attempted to stop him there was an exchange between the 2 and he got scratched by her fingernails. He has a very small abrasion underneath his left eye and a larger abrasion on his right inner forearm. He has been moved to another unit and this morning he is lying in bed and calm. He does remember the exchange and tells me that woman tried to stop me from going in that room he does not seem to understand that the room he was entering was not a common area .Physical Exam .Skin .Approximate 1 cm [centimeter] abrasion below the left eye there is no bleeding it does appear infected and he is able to see out of this eye .Approximate 4 cm x 2 cm abrasion on right forearm appears somewhat superficial there is no redness or drainage noted and no swelling .Psychiatric .Alert, he is calm at present and resting in bed in no distress .Diagnosis and Assessment .Abrasion, face w/o [without] infection . Abrasion of right upper extremity .Plan: Clean abrasions with warm soapy water and rinse and pat dry. apply triple antibiotic daily, place non-stick covering over arm abrasion and wrap with clean dry dressing daily. monitor for infection . Review of a Safety Check for Resident #46 dated 2/11/2024 showed behaviors and mood checks every 15 minutes starting at 9:00 PM and continued to 9:00 PM on 2/12/2024. Resident #44 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Generalized Anxiety Disorder and Hypertension. Review of an annual MDS assessment dated [DATE], showed Resident #44 had a BIMS of 12, which indicated the resident had moderate cognitive impairment. Resident #44 exhibited no behavioral symptoms. Review of the care plan dated 11/16/2021 showed Resident #44 had a .Behavior Care Plan .Potential for impaired or inappropriate behaviors related to delusions and hallucinations . with interventions including . Administer medications as ordered. Observe/document for side effects and effectiveness .Observe behavior episodes and attempt to determine underlying cause . Review of a Safety Check for Resident #44 showed behaviors and mood checks every 15 minutes that started at 9:00 PM on 2/11/2024 and continued until 9:00 PM on 2/12/2024. (continued on next page)

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F 0609 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Progress Note for Resident #46, dated 2/12/2024 at 8:44 AM, showed NP #1 followed up with Resident #44 after an altercation with another resident. It was noted .Chief Complaint/Nature of Presenting Problem: Follow up on encounter with another resident .She likes to sit in or near her doorway in the hallway. Last night she was sitting there speaking with another resident when a confused resident came and attempted to get into her room. According to [Resident #44] they had a verbal exchange and he attempted to hit her and in the exchange she accidently scratched him with her fingernail. She denies injury and the other resident has been moved to another hall. She tells me he accused her of attacking him however she was just attempting to defend herself .Physical Exam .Psychiatric: Calm .Diagnosis, Assessment and Plan .Continue to monitor for signs of latent injury. The other resident has been moved and she is call [calm] and in no distress . During an interview

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on facility policy review, medical record review, and interview, the facility failed to investigate an injury of unknown origin and three resident-to-resident altercations as the potential for abuse for 7 of 37 (Residents #39, #73, #24, #46, #44, #40, and #91) sampled residents reviewed for abuse. Resident #39, a vulnerable and severely cognitively impaired, non-ambulatory resident, with bilateral leg contractures, sustained a left femur fracture with an undetermined cause. On 12/20/2023, Resident #39 verbalized increased pain and staff observed swelling in her right lower leg. She was sent to the emergency room (ER) and radiology tests identified a left femur fracture on 12/21/2023. Facility documentation identified right leg pain and swelling, but there was no documentation of left leg pain or swelling in the facility's medical record. The facility failed to complete a thorough investigation into Resident #39's injury of unknown origin. On 2/9/2024, Staff observed Resident #73 and Resident #24, both vulnerable and severely cognitively impaired residents who were roommates, slapping each other in the residents' room. Resident #73 sustained a bruise to the bridge of the nose when the altercation occurred, and Resident #24 sustained an abrasion on top of the scalp, redness to the face, and a bruise to the bridge of the nose. On 2/11/2024 Resident #46, a vulnerable and moderately impaired resident with a history of hallucinations, sustained a scratch to the face and right forearm after an altercation with Resident #44, when he attempted to enter Resident #44's room, who was also moderately cognitively impaired. On 3/30/2024, staff observed Resident #40, a vulnerable and severely cognitively impaired resident with a known history of agitation, combativeness, and abusive and aggressive behaviors, in an altercation with Resident #91. Resident #91, a vulnerable and severely cognitively impaired resident with known aggressive behaviors, sustained 3 scratch marks to the left cheek and 1 scratch mark to the left eyebrow during the altercation with Resident #40. Resident #91's injuries were open, bleeding, and required first aid. The facility's failure to identify and investigate potential abuse resulted in a failure to investigate abuse allegations and an injury of unknown origin which placed Residents #39, #73, #24, #46, #44, #40, and #91 in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements for participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). The facility's failure to investigate resident-to-resident altercations and an injury of unknown origin had the potential to impact all 101 residents in the facility. The Administrator, Director of Nursing (DON), [NAME] President (VP) of Regulatory Compliance and QAPI (Quality Assurance and Performance Improvement) Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-610 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited Immediate Jeopardy at F-610 at a scope and severity of K which constituted Substandard Quality of Care. An Extended survey was conducted onsite from 4/10/2024 and 4/11/2024. The IJ began on 12/21/2023 and continued through 4/9/2023. The IJ ended on 4/10/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/10/2024 for F-610. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The corrective actions were validated on site by the surveyor on 4/11/2024 for F-610. Noncompliance at F-610 continues at a scope and severity of E for monitoring the effectiveness of the corrective action. The facility is required to submit a Plan of Correction (POC). The findings include: Review of the facility's policy titled, Abuse Prohibition/Investigative Policy, revised on 11/2016, showed . facility will prohibit abuse .will be completed for all residents through .Identification of possible incidents or allegations which need investigation .Investigation of incidents and allegations .The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse .The Administrator is responsible for implementation of the policies and procedures that prohibit abuse .The investigation documentation will be noted on the following forms .The Resident Abuse Investigation Report form .The Abuse Log .The AHCA Federal Immediate/5 Day Report form .The Administrator will report findings of all completed investigations per state requirements. The reporting format must include all of the following .Name of Resident .Date and time incident occurred .Circumstances surrounding the incident . Where the incident took place .Name of any witnesses .Name of person(s) alleged to have committed the act .Immediate corrective/protective action taken .Notifications: Law Enforcement, Complaint Administration unit (CAU) .The Administrator/Designee will analyze the completed and documented investigation, for accuracy and completeness . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised on 4/2021, showed .Residents have the right to be free from abuse .includes .physical abuse . Identify and investigate all possible incidents of abuse .Investigate .any allegations within timeframes required by federal requirements . Review of the facility's undated policy titled, Unusual Occurrences, showed .Unusual occurrences may include .Resident to resident altercation .Notify the DON [Director of Nursing]/Administrator: For any unusual occurrence that may be related to .abuse, the facility will follow the abuse policy . Review of the facility's undated policy titled, Injury of Unknown Source, showed .This policy will provide guidelines related to unexplainable injuries .injuries of unknown source will be investigated .if the injury is of unknown source .investigation procedures shall be implemented in accordance with the facility's abuse policy and procedures .An injury should be classified as an 'injury of unknown source' when .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of .the extent of the injury . Resident #39 was admitted to the facility on [DATE] with diagnoses including Dementia, Abnormal Gait and Mobility, and Maltreatment. Review of the History and Physical for Resident #39 dated 5/31/2022, showed Resident #39 was non ambulatory and unable to sit in a wheelchair due to bilateral leg contractures. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the quarterly MDS assessment dated [DATE], showed Resident #39 had a BIMS score of 7, which indicated the resident had severe cognitive impairment and required substantial/maximal assistance with mobility. Review of the Nursing Progress note for Resident #39 dated 12/20/2023, showed .CNA reported to nurse . resident .verbalizing pain upon movement in bed .requesting to go to ER [emergency room]. Resident assessed .Alert and Orientated x [times] 3 [oriented to person, place, and time] .Resident verbalizing pain in right leg .leg .swollen to up to right hip .+2 pitting edema in Right foot .Bilateral pedal pulses are noted . Capillary refill isWNL [is within normal limits] bilateral. Resident vocalizes pain to touch BLE [bilateral lower extremities]. Vitals are WNL .DON notified. Awaiting EMS [emergency medical service] for transport to ER . Review of the hospital History and Physical for Resident #39 dated 12/21/2023, showed Resident #39 presented to the hospital with left knee pain (facility documentation showed right leg). Review of the hospital radiology report dated 12/21/2023, showed Resident #39 had osteopenia with a left femur fracture (actual fracture was left femur and conflicting documentation of right leg pain from the facility). Review of the Orthopedic Consult Note for Resident #39 dated 12/21/2023, showed upon physical examination the left distal femur had soft tissue swelling with tenderness to the left distal femur region. The case was reviewed and discussed with consideration of Resident #39's comorbidities; .may consider speaking with guardian of the possibility and benefit of above the knee amputation. The likelihood of the fracture healing is low . Review of the medical record for Resident #39's showed no documentation an incident report or thorough investigation had been completed related to the left leg injury. During a telephone interview on 4/3/2024 at 8:10 PM, Licensed Practical Nurse (LPN) #6 stated she was the nurse who sent Resident #39 out to the hospital on 12/20/2023, when the resident complained of right leg pain and swelling. She notified NP #1 and the DON about the right leg pain and swelling, and orders were received to send the resident out to the ER for evaluation. During an interview on 4/4/2024 at 4:50 PM, the DON stated Resident #39's fracture was brought to her attention on 12/21/2023, after being sent to the hospital and x-rays confirmed the left femur fracture. There was no incident report and staff interviews were all that was obtained for investigation. The DON stated the incident was not a reportable event. When the DON was asked if the incident met the definition of an injury of unknown origin; she stated, I didn't think about that. The DON confirmed neither a formal investigation nor a root cause analysis was conducted. The DON confirmed an incident report was not completed and a thorough investigation to determine the root cause of the fracture was not completed. (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 - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/5/2024 at 10:55 AM, the Administrator stated she was aware Resident #39 had been sent to the hospital and identified with a fracture on 12/21/2023. Staff interviews were conducted by the DON after she and the DON were notified of Resident #39's fracture. The Administrator stated a root cause analysis meeting was not held and her determination of the root cause of the fracture was solely based off staff interviews. The Administrator stated she was .the abuse coordinator for the facility . and there was no discussion that Resident #39's fracture could have possibly been identified as an injury of unknown origin. The Administrator said she was aware serious physical harm was reportable within 2 hours based on regulatory agencies and she was able to make the determination within 2 hours of being made aware of Resident #39's fracture, the cause of the injury from staff interviews. The Administrator confirmed the facility did not follow their policies for identifying, investigating, and reporting injuries of unknown origin. 41782 Resident #73 was admitted to facility on 11/23/2022 and readmitted on [DATE] with diagnoses including Right Femur Fracture, Dementia, Abnormalities of Gait and Mobility, Lack of Coordination, and Symptoms and Signs Involving Cognitive Functions and Awareness. Review of the care plan dated 12/2/2022, showed Resident #73 had .impaired cognitive function/dementia or impaired thought processes r/t Dementia .communication problem r/t usually understands and usually makes self understood .ADL [activities of daily living] Care Plan .self-care performance deficit r/t weakness . Interventions .requires x[times]1 staff to turn .reposition in bed .toileting .assistance needed with transfers . Resident #73's care plan did not reflect the resident to resident altercation on 2/9/2024. Review of the annual MDS assessment dated [DATE], showed Resident #73 had a BIMS score of 4, which indicated the resident had severe cognitive impairment and required substantial/maximal assistance with chair/bed transfers. Resident #73 exhibited no behavioral symptoms. Review of the SKIN- Head to Toe Weekly Skin Checks for Resident #73 dated 2/8/2024, showed the resident had a surgical wound to the right hip, excoriation to the buttocks, a blister to the left foot, stage 2 pressure wound, and a left elbow skin tear. No other skin impairments were noted. Review of the Nursing Note for Resident #73 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident and the other resident [Resident #24] residing in the room. Assisted by the CNA the nurse was able to deescalate the situation. The other resident was removed from room, and this resident was assessed for injury. The resident was noted to have a small bruise at the bridge of the nose where glasses rest. Vitals WNL. DON notified, NP, and POA .notified of situation. 15-minute safety checks initiated for the next 24 hours. Residents' roommate received room change. Resident calm and ready to go to sleep. Bed locked and in lowest position, call light and fluid in reach . Review of the facility document titled, RESIDENT SAFETY CHECK, for Resident #73 dated 2/9/2024, showed .Check Every .15 Minute Check .Safety Concerns .Behaviors/Mood .Altercation with Resident . Continued review showed every 15-minute checks were started on 2/9/2024 at 7:30 PM and ended on 2/10/2024 at 7:45 PM. (continued on next page)

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	445292	A. Building B. Wing	04/11/2024

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Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the SKIN- Head to Toe Weekly Skin Checks for Resident #73 dated 2/10/2024, showed the resident had new skin impairment and it was noted .Site .Face .Description .Bruising to bridge of nose . Resident #24 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Alzheimer's Disease, Dementia, Abnormalities of Gait and Mobility, and Muscle Weakness. Review of the comprehensive care plan for Resident #24 dated 8/22/2016, last revised on 4/23/2021, showed .I have impaired cognitive function r/t Dementia . Resident #24's care plan was not updated to reflect the resident to resident altercation on 2/9/2024. Review of the quarterly MDS assessment dated [DATE], showed Resident #24 had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #24 exhibited no behavioral symptoms. Review of a SKIN- Head to Toe Weekly Skin Checks for Resident #24 dated 2/8/2024, showed the resident had no areas of skin impairment. Review of a Nursing Note for Resident #24 dated 2/9/2024 at 7:30 PM, showed .The nurse entered the room and witnessed an altercation between resident [Resident #24] and the other resident residing in the room. Assisted by the CNA the nurse was able to deescalate the situation. The resident was separated and assessed for injury. The resident was noted to have small abrasion to top of scalp, fading redness on face, and bruise at the bridge of nose where glasses rest. Vitals WNL [Within Normal Limits]. DON notified, NP, and [NAME] [Niece] .notified of situation. 15-minute safety checks initiated for next 24 hours .Resident received room change: Resident now residing in 223A. Roommate in agreement. Resident oriented to new room, call light and bed control. Bed locked and in lowest position call light in reach . Review of a Room Change Notification note dated 2/9/2024 at 7:30 PM, showed Resident #24's .Resident Representative Notified via: Phone . Review of a facility document titled, RESIDENT SAFETY CHECK, for Resident #24 dated 2/9/2024, showed . Check Every .15 Minute Check .Safety Concerns .Behaviors/Mood .Altercation [with] Resident . Continued review showed every 15-minute safety checks started at 7:30 PM on 2/9/2024 and ended on 2/10/2024 at 7:45 PM. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility document titled SEC [Significant Event Call] WORKSHEET, dated 2/9/2024 at 8:30 PM, showed the altercation with Resident #24 and #73 was discussed. It was noted Resident #73 had a BIMS score of 4 and Resident #24 had a BIMS score of 3 and both residents had a diagnosis of Dementia. Continued review showed .Location: in [Resident #24 and #73's room] .What occurred: nurse witnessed altercation .Witnesse(s): [Registered Nurse] [RN #5] .Incident report completed: Yes .No . was not completed. Further review showed .Identify everyone who was involved in, or witnessed, or has first hand information about the event and attach to worksheet: [RN #5] .Staff/witnesses interviewed- statements obtained: P [progress] note / DON verbal interview .Dx [diagnosis]: Both have dementia .Care plan up to date: Yes .Status of investigation Responsibility assigned to: DON/NHA [Nursing Home Administrator] .Is it reportable .No .Notified Entities .DOH [Department of Health] .No Family: Date notified .2/9/24 .MD [Medical Doctor]: Date notified .2/9/24 .Root Cause analysis .Dementia/Cognition .per SEC call .Status of resident . Safe .If altercation .Resident(s) on 1:1 or on 15-minute checks .Immediate Ad-Hoc [a meeting held for a specific purpose or reason] QAPI meeting .2/12/24 [2024] .4:30 pm [PM] .Staff de-escalated [and] separated appropriately/POC [plan of care] not needed .RECOMMENDATIONS from call .15 min check for 24 hrs . Room change .DON initiated . Review of facility documentation showed attendees on the SEC call dated 2/9/2024, Resident #24 and #73's altercation was discussed with the Administrator, DON, Director of Resident Advocate Program, [NAME] President of Operations, VP of Regulatory Compliance and QAPI Program Consultant, Chief Regulatory and Compliance Officer, and the VP of Clinical Services. Review of the facility's investigation documentation for the resident-to-resident altercation between Resident #24 and #73 on 2/9/2024 provided to this surveyor included the Nursing Note for Resident #73 dated 2/9/2024, the SEC Worksheet dated 2/9/2024, Resident #73's face sheet with diagnosis list, Resident #24 and #73's RESIDENT SAFETY CHECKs started on 2/9/2024 at 7:30 PM and ended on 2/10/2024 at 7:45 PM, and the Ad HOC Res [Resident] to Res QAPI ATTENDANCE SIGN IN SHEET dated 2/12/2024. The investigation did not include witness statements or resident interviews. Review of a Skin observation progress note for Resident #24 dated 2/10/2024 at 4:37 AM, showed .Resident has a new skin impairment .Top of Scalp-skin abrasion .bruising to bridge of nose, and upper right forehead. Responsible party notified . During an interview on 4/5/2024 at 12:20 PM, the Administrator stated she was the facility's abuse coordinator and was ultimately responsible for abuse investigations. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a telephone interview on 4/5/2024 at 7:32 PM, RN #5 stated she was assigned to provide care for Residents #24 and #73 on the night (2/9/2024) of the altercation. RN #5 was at the nurses' station and heard a noise that startled her. RN #5 immediately went down the hallway to investigate the noise and determined the noise was coming from Resident #24 and #73's room. RN #5 entered the room and observed Resident #24 seated in a chair next to Resident #73's bed and closet and Resident #73 was in his bed leaning over the side. RN #5 stated Resident #24 was .getting in . Resident #73's closet and the residents were .open hand slapping each other . RN #5 stated Resident #24 was trying to remove clothes from Resident #73's closet. RN #5 stated she and an unknown CNA separated the residents and Resident #24 was removed from the room to de-escalate the situation. Resident #73 had a small bruise on the bridge of his nose that was gone the next night. Resident #24 had a small bruise on the bridge of his nose where his glasses were, a small abrasion on the top of his head, and scattered redness on his face that faded within a few hours. RN #5 stated Resident #73's speech was hard to understand but the resident was able to tell her .he's in my stuff .get him out of my room . and Resident #24 said .this is my stuff . RN #5 notified the DON via phone immediately of the incident and the DON reported to the facility after the incident. RN #5 stated she .thought . the DON asked her to write a statement but was unable to recall for sure. RN #5 was unable to recall if she had completed an incident report for the altercation. During a telephone Interview on 4/6/2024 at 9:09 AM, Licensed Practical Nurse (LPN) #6 stated she worked the night (2/9/2024) of the altercation between Residents #24 and#73 and was aware of the altercation. LPN #6 saw RN #5 moving quickly down the hallway and asking for help. LPN #6 entered the room to assist RN #5. Residents #24 and #73 were already separated when LPN #6 entered the room and LPN #6 removed Resident #24 from the room to de-escalate the situation. Resident #24 told LPN #6 that Resident #73 .beat him up . The LPN stated .I think he [Resident #24] had a small scratch on his head .I can't remember what other injuries he had . LPN #6 stated that Resident #73's shoes were found in Resident #24's closet. LPN #6 stated RN #5 notified the DON immediately after the incident and the DON came to the facility. LPN #6 stated she provided a witness statement. During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2024 at 10:58 AM, the DON stated RN #5 notified her via telephone that Resident #24 had gotten into Resident #73's closet and Resident #73 hit Resident #24 on top of the head. The residents were roommates at the time of the incident. RN #5 entered the room while the altercation was happening and observed the residents hitting each other. The DON confirmed both residents were injured because of the altercation. Resident #24 had an abrasion on his head, redness to his face, and a bruise on his nose. Resident #73 had a small bruise on the bridge of his nose. The DON came to the facility to investigate the altercation immediately after she was notified by RN #5. The DON confirmed the DON and Administrator were responsible for completing abuse investigations. The DON stated she obtained statements from all staff working that night and .I don't know where they are at . Abuse investigations were to include statements from all staff present at the time of the altercation and interviews with the involved residents. The DON confirmed the there was no documentation of the facility's investigation other than the SEC Worksheet, RESIDENT SAFETY CHECKS, and QAPI ATTENDANCE SIGN IN SHEET. This surveyor reviewed the facility's Abuse Prohibition/Investigative Policy with the DON and the DON confirmed the facility did not follow the policy for abuse investigations and a complete and thorough investigation had not been conducted for the resident-to-resident altercation between Residents #24 and #73. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2023 at 12:33 PM, the Administrator stated she .vaguely . recalled the resident-to-resident altercation between Residents #24 and #73. RN #5 witnessed an altercation between the residents on 2/9/2023.From my recollection ., the residents were roommates and had a physical altercation about one being in the other's closet and they were separated . The Administrator was made aware of the altercation by the DON but was unable to recall the date or time. The Administrator stated investigations were the responsibility of the DON and the Administrator. The DON interviewed staff regarding the incident and the Administrator reviewed the medical records for the residents. Record review by the Administrator included review of the BIMS score, age, and ambulation status of each resident involved. The BIMS score was reviewed to determine if the resident could have acted willfully or not. The DON and Administrator discussed their findings and arranged an SEC call with members of the governing body to discuss the altercation and determine if the altercation was reportable to the state designated authorities. Upon review of the nursing documentation provided to this surveyor regarding the altercation, the Administrator confirmed Resident #24 sustained a small abrasion to the top of the scalp, redness on the face, and a bruise to the bridge of the nose and Resident #73 sustained a bruise to the bridge of his nose where his glasses rested. The Administrator confirmed both residents sustained injuries from the altercation. This surveyor reviewed the investigation documentation provided by the facility with the Administrator that included Resident #73's face sheet with diagnosis list, Resident #73's Nursing Note dated 2/9/2024, RESIDENT SAFETY CHECKS documentation for Residents #24 and #73 which started on 2/9/2024 at 7:30 PM and ended on 2/10/2024 at 7:45 PM, and the SEC Worksheet. The Administrator confirmed there was no other investigation documentation for the resident-to-resident altercation. This surveyor reviewed the facility's Abuse Prohibition/Investigative Policy and the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policy with the Administrator. The Administrator confirmed the facility did not follow its policies for abuse investigations and a complete thorough investigation was not completed. The Administrator confirmed it was her expectation that federal regulations were followed. During an interview on 4/8/2024 at 12:20 PM, the VP of Regulatory Compliance and QAPI Program Consultant, confirmed it was her expectation that a complete and thorough investigation was conducted for all resident-to-resident altercations. Investigations should include statements from all staff involved, all staff on the unit, resident interview (if possible), assessments of the resident, and input from the provider. The investigation documentation should be uploaded in the facility's computer system. The VP of Regulatory Compliance and QAPI Program Consultant confirmed the facility did not do a complete and thorough investigation for the resident-to-resident altercation between Residents #24 and #73. 45837 Resident #46 was admitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Unspecified Dementia, Unspecified Severity, With Psychotic Disturbance and Anxiety Disorder. Review of the annual MDS assessment dated [DATE] showed Resident #46 had a BIMS of 11, which indicated the resident had moderate cognitive impairment, and exhibited no behavioral symptoms. Review of a Progress Note for Resident #46 dated 2/12/2024 at 8:58 AM, showed NP #1 saw the resident after a resident-to-resident altercation where Resident #46 received an approximate 1 centimeter (cm) abrasion under his left eye and a 4 cm by 2 cm abrasion his right forearm. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Head to toe weekly Skin Check for Resident #46 dated 2/19/2024, showed Resident #46's skin issue was a surgical incision and healing abrasions under left eye and right forearm. Review of the medical record for Resident #46 showed no additional documentation of the resident-to-resident altercation dated 2/11/2024 between Resident #46 and Resident #44. Resident #44 was admitted to the facility on [DATE] with diagnoses including Unspecified Dementia, Generalized Anxiety Disorder and Hypertension. Review of the care plan revised on 11/25/2020 showed Resident #44 had .impaired cognitive function r/t my Dementia .history of Paranoia and hallucinations .may misunderstand others r/t my confusion . Resident #44's care plan did not reflect the resident to resident altercation on 2/11/2025. Review of the care plan revised on 4/5/2024 showed Resident #44 had a .Behavior Care Plan .Potential for impaired or inappropriate behaviors related to delusions and hallucinations . Resident #44's care plan did not reflect the resident to resident altercation on 2/11/2025. Review of the annual MDS assessment dated [DATE], showed Resident #44 had a BIMS of 12, which indicated moderate cognitive impairment, and exhibited no behavioral symptoms. Review of the Safety Check for Resident #44 showed behaviors and mood checks every 15 minutes that started at 9:00 PM on 2/11/2024 and continued until 9:00 PM on 2/12/2024. Review of the NP Progress Note for Resident #44, dated 2/12/2024 at 8:44 AM, showed NP #1 followed up with Resident #44 after an altercation (on 2/11/2024) with Resident #46. It was noted .Chief Complaint/Nature of Presenting Problem: Follow up on encounter with another resident .She [Resident #44] likes to sit in or near her doorway in the hallway. Last night she was sitting there speaking with another resident when a confused resident [Resident #46] came and attempted to get into her room. According to [Resident #44] they had a verbal exchange and he attempted to hit her, and in the exchange, she accidently scratched him with her fingernail. She denies injury and the other resident has been moved to another hall. She tells me he accused her of attacking him however she was just attempting to defend herself .Physical Exam .Psychiatric: Calm .Diagnosis, Assessment and Plan .Continue to monitor for signs of latent injury. The other resident has been moved and she is call [calm] and in no distress . Review of the medical record for Resident #44 showed no additional documentation of the resident-to-resident altercation between Resident #44 and Resident #46. During an interview on 4/8/2024 at 10:19 AM, the DON stated there was no documentation of an incident report or investigation for a resident-to-resident altercation between Resident #44 and Resident #46 on 2/11/2024. The DON stated the nurse told her about the altercation between Residents #44 and #46 the next morning as she was leaving her shift, but it was not considered abuse due to the poor cognition level of each resident. The DON confirmed the incident had not been reported to the state designated authorities or investigated per the facility's policy. (continued on next page)

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F 0610 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/8/2024 at 11:58 AM, NP #1 stated Resident #44 stated Resident #46 tried to gain access to Resident #44's room, she tried to protect herself and accidentally scratched Resident #46's arm. The nurses told her, she could not remember which nurse told her, about the event and she had seen both residents. The NP stated she did not report the altercation to anyone else. During an interview on 4/8/2024 at 12:03 PM, Resident #44 stated a man came to her room, tried to get into the room, and she didn't want him in the room. The resident stated the man kept pushing at her trying to get in the room. She denied the resident hit her. The resident stated he finally went on his way, but he is still here [in the facility] .Everyone seems to be more upset about it than I am . When asked how it made her feel, the resident stated she was not afraid of her neighbors or harmed in any way. During a telephone interview on 4/8/2024 at 3:16 PM, LPN #8 stated she worked at the facility on 2/11/2024, and at about 9:00 PM, a CNA came and got LPN #8 when the CNA heard raised voices. There was no eyewitness to the event, but all she remembered was Resident #46 was trying to go into Resident #44's room, and she kept telling him no. LPN #8 stated Resident #46 had behaviors of hallucinations, and that could have been what was happening to lead him into Resident #44's room. LPN #8 separated the residents and took Resident #46 back to the secure unit where she was stationed. LPN #8 stated she performed 15-minute behavior checks, not because someone told her to at that time, but stated .it's just always what we do when something like that happens . or when 2 residents had an altercation. LPN #8 stated she thought she did a skin assessment and an incident report. LPN #8 stated she was unsure if she had told the DON, the NP, or the residents' families about the incident. LPN #8 did not remember the names of any other staff who was helping her that night. Any time LPN #8 suspected abuse, she stated she immediately contacted the Administrator, the DON, the resident's representative and the provider (although could not recall if she had notified them after this altercation). LPN #8 stated she did not consider the altercation between Residents #44 and #46 abuse because .they were both confused . During an interview on 4/9/2024 at 12:10 PM, with the DON and the Administrator, the Administrator stated for an allegation to be valid or considered abuse, .the resident has to understand

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on review of the Resident Assessment Instrument Manual 3.0 (RAI), medical record review, and interview, the facility failed to accurately complete Minimum Data Set (MDS) assessments for 4 Residents (#39, #78, #20, and #46) of 31 residents reviewed for MDS assessments. The findings include: Review of the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.18.11 dated ,d+[DATE], showed .assessments and documentation can be compared to baseline to identify changes in the resident's behavior .Review the medical record for the 7-day look-back period .Interview staff, across all shifts and disciplines, as well as others who had close interactions with the resident during the 7-day look-back period, including family or friends who visit frequently or have frequent contact with the resident .Observe the resident in a variety of situations during the 7-day look-back period .Active Diagnoses .to code diseases that have a direct relationship to the resident's current functional status .important functions of the MDS assessment is to generate an updated, accurate picture of the resident's current health status . Resident #39 was admitted to the facility on [DATE] with diagnoses including Dementia, Abnormal Gait and Mobility, and Maltreatment. Review of a hospital radiology report for Resident #39 dated [DATE], showed a left femur fracture. Review of a History and Physical dated [DATE], showed Resident #39 had an .impacted fracture .left femur . they [hospital] wanted to do an amputation .was not eligible for corrective surgery, however, [resident] refused .returned to the facility yesterday .Closed fracture .left femur with routine healing, unspecified fracture morphology . Review of a quarterly MDS assessment dated [DATE], showed no documentation on the MDS Resident #39 had a left femur fracture. During a telephone interview on [DATE] at 2:55 PM, the Regional Remote MDS Coordinator confirmed Resident #39's MDS assessment dated [DATE] was inaccurate and did not capture the femur fracture that was diagnosed [DATE]. 41782 Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Mild Neurocognitive Disorder, Post Traumatic Stress Disorder (PTSD), Nightmare Disorder, Anxiety, and Depression. Review of a physician order for Resident #78 dated [DATE], showed an order for Buspirone (a medication used to treat generalized anxiety disorder) 10 milligrams (mg) by mouth three times daily. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a History and Physical dated [DATE], showed Resident #78 .DIAGNOSIS/ASSESSMENT/PLAN . Dementia with behavior disturbance/PTSD .will refer to psychiatric service .Depression .Anxiety .Anxiety: buspar 10 mg PO [by mouth] TID [three times a day] . Review of a quarterly MDS assessments dated [DATE],[DATE], and [DATE], showed Resident #78 had an active diagnoses for Depression. Anxiety was not checked. Review of the Medication Administration Record (MAR) for Resident #78 dated [DATE] - [DATE], showed the resident received Buspirone 10 mg by mouth three times daily according to the physician's order. During an interview on [DATE] at 8:45 AM, the Director of Nursing (DON) confirmed the resident had a diagnosis of Anxiety. The DON confirmed the MDS assessments dated [DATE], [DATE], and [DATE] were inaccurate and did not include the resident's diagnosis of anxiety. 50216 Resident #20 was admitted to the facility on [DATE] with diagnoses of Lack of Coordination, Diabetes Mellitus Type 2, Intellectual Disabilities, Major Depressive Disorder and Anxiety Disorder. Review of a progress notes for Resident #20 dated [DATE], showed .Resident noted to be visibly agitated walking up hallway from her room. Resident went into dayroom A and turned over 4 chairs and turned over the trash can . Resident #20 stated .someone took my blanket . Review of a quarterly MDS assessment dated [DATE], showed Resident #20 had moderate cognitive impairment. Resident #20 had not exhibited any behaviors during the assessment period. During an interview on [DATE] at 8:37 AM, the Social Service Director (SSD) stated it was her job to complete the monthly Social Service Assessment section of the MDS and was unaware of behaviors for Resident #20 on [DATE]. The SSD confirmed the documented behaviors should have been captured on the MDS. During an interview on [DATE] at 5:22 PM, the SSD stated the information for the MDS comes from talking to the resident and staff, reviewing the chart including progress notes, CNA notes and activity notes. The SSD confirmed the documented behaviors should have been included on the quarterly MDS assessment. 45837 Resident #46 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Dementia, With Psychotic Disturbance and Anxiety Disorder. Review of a care plan dated [DATE], showed Resident #46 had .hallucinations .state .I see my dead wife . when I am having Hallucinations, provide supportive listening as needed . (continued on next page)

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Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Social Service (SS) quarterly progress note for Resident #46 dated [DATE], showed .Quarterly review [resident's name] is alert and has confusion. He is up as tolerated in w/c [wheelchair]. He goes about the facility. Likes to socialize with others. At times he will talk with his dead wife whom he states is outside the windows he will say know one can see her but him. Psy. [psychiatric] services follows him. SS will continue to visit and follow . Review of an annual MDS assessment dated [DATE], showed Resident #46 had not exhibited any behaviors during the assessment period. During an interview on [DATE] at 1:41 PM, Registered Nurse (RN) #2 stated Resident #46 would fixate on females during hallucinations and thought he was seeing his deceased wife. During an interview on [DATE] at 4:22 PM, the DON reviewed the quarterly MDS assessment dated [DATE] and noted that no hallucinations or delusions were assessed on the assessment. The DON confirmed that resident #46 had behaviors of hallucinations and delusions and the behaviors should have been included on the MDS assessment dated [DATE].

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on medical record review and interview, the facility failed to resubmit a Pre-Admission Screening and Resident Review (PASRR) timely after a new mental health diagnosis for 2 residents (Residents #27 and #78) of 12 residents reviewed for PASRR. The findings include: Review of the facility's undated policy titled, PASARR Program, showed .This facility will provide guidance to the facility staff related to completion of PASARR screening .The goal is to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most integrated setting appropriate to their needs .PASARR Level I - initial pre-screening that is completed prior to admission .Negative Level I Screen- permits admission to proceed and ends the PASARR process unless a possible serious mental disorder or intellectual disability arises later .Any resident who exhibits a newly evident or possible serious mental disorder .will be referred promptly to the state mental health or intellectual disability authority for a level II resident review .Examples include .A resident whose .related condition was not previously identified and evaluated through PASARR . Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Psychosis, Depression, Post Traumatic Stress Disorder (PTSD), Agoraphobia (an anxiety disorder involving panic attacks), and Panic Disorder. Review of a Notice of PASRR Level I Screen Outcome for Resident #27 dated 12/7/2021, showed the resident had diagnoses of .Trauma/Stress Related Disorder (Suspected) .Depression - mild or situational (Suspected) .agoraphobia with panic disorder . It was also noted the resident had a diagnosis of . dementia/neurocognitive disorder . It was noted .Level I Outcome: No Level II Condition- Level I Negative . Documentation reviewed and reports depression, PTSD, and agoraphobia with panic disorder and added to review as a suspected diagnosis. Based on the information received, there is no history or indicators of a major mental illness .A Level II evaluation is not required and this Level I is approved with a Level I Negative outcome. If the nursing facility (NF) determines any inaccuracies in diagnoses a Status Change review will be required . Review of a History and Physical for Resident #27 dated 12/9/2021, showed .PAST MEDICAL HX [history] . PTSD with agoraphobia and panic disorder .Psychosis, delusional disorder .ASSESSMENT/PLAN .Anxiety . Psychosis .consult psychiatric service to follow .Depression . Review of a Psychiatric Progress Note for Resident #27 dated 9/19/2022, showed a new diagnosis of .MDD [Major Depressive Disorder] . was added. Review of a comprehensive care plan for Resident #27 showed the resident was care planned for depression. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/2024 at 9:43 AM, the Director of Nursing (DON) stated Resident #27's Level I PASRR dated 12/7/2021 included a diagnosis of suspected mild or situational depression. Resident #27 had a new diagnosis of Major Depressive Disorder added on 9/19/2022. The DON confirmed the facility had not resubmitted the PASRR to include the new diagnosis of Major Depressive Disorder and stated .it should have been .Major Depressive Disorder is not the same as mild or situational depression . Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Mild Neurocognitive Disorder, PTSD, Nightmare Disorder, Anxiety, and Depression. Review of a Level I Form Pre-Admission Screening and Resident Review for Resident #78 dated 3/16/2023, showed .DIAGNOSIS .Trauma/Stress Related Disorder .Depression - mild or situational . It was noted the resident had a diagnosis of dementia/neurocognitive disorder. Continued review showed .OUTCOME .Level I Outcome: No Level II Condition- Level I Negative . Review of a History and Physical for Resident #78 dated 4/3/2023, showed .CHIEF COMPLAINT: Dementia, Confusion, PTSD .history of PTSD, Neurocognitive disorder, nightmare disorder .PAST MEDICAL HISTORY . Chronic PTSD .Neurocognitive disorder .Nightmare disorder .Dementia .Depression . DIAGNOSIS/ASSESSMENT/PLAN .Dementia with behavior disturbance/PTSD .will refer to psychiatric service .Depression .Anxiety . Review of a Progress Note for Resident #78 dated 4/17/2023, showed a diagnosis of .MDD [Major Depressive Disorder] . had been added. Review of a Mental Health Progress Note for Resident #78 dated 4/19/2023 and 4/27/2023 showed DX . MDD . During an interview on 4/3/2024 at 8:45 AM, the DON stated she was responsible for PASRRs. Resident #78's Level I PASRR dated 3/16/2023 included a diagnosis of mild or situational depression. The DON confirmed Resident #78 had a new diagnosis of Major Depressive Disorder added on 4/17/2023. The DON confirmed a new PASRR was not submitted and should have been.

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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** 50216 Based on facility policy review, medical record review, observations and interviews, the facility failed to develop and implement a comprehensive person-centered care plan for 9 residents (Residents #91, #40, #24, #73, #44, #46, #39, #20, and #78) of 37 residents reviewed for comprehensive care plans. The facility failed to address Resident #40's history of aggressive behaviors, with appropriate interventions. The facility failed to develop and implement a person-centered care plan related to Resident #91's wandering behaviors. Care plans were not developed to reflect the resident to resident altercations between Residents #40 and #91 on 3/30/2024, where Resident #91 sustained 3 scratches to the left cheek and 1 scratch above the eyebrow, Residents #24 and #73's altercation on 2/9/2024, where Resident #24 sustained an abrasion to the top of the head, redness to the face, and a bruise at the bridge of the nose and Resident #73 sustained a bruise to the bridge of the nose. Residents #44 and #46's care plan was not developed to reflect the resident-to-resident altercation between Resident #44 and #46 on 2/11/2024, where Resident #46 sustained a scratch to the left face and right forearm. The facility's failure to develop and implement person centered care plans placed Residents #91, #40, #24, #73, #44, and #46 in Immediate Jeopardy (IJ) (A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious harm, impairment, injury or death of a resident and must be immediately corrected). The facility failed to develop and implement a person-centered comprehensive care plan for Resident #39's left femur fracture, Resident #20's behaviors, and Resident #78's active diagnoses of Depression and Anxiety. The facility's failure to develop and implement person centered behavioral care plans contributed to resident-to-resident abuse and had the potential to impact all 101 residents in the facility. The Administrator, Director of Nursing (DON), [NAME] President (VP) of Regulatory Compliance and QAPI (Quality Assurance Performance Improvement) Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited IJ at F-656 at a scope and severity of K. An extended survey was conducted onsite on 4/10/2024-4/11/2024. The IJ began on 1/11/2024 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. An acceptable removal plan, which removed the immediacy of the jeopardy, was provided by the facility on 4/10/2024 for F656. Noncompliance continues at F656 at a scope and severity of E for monitoring the effectiveness of the corrective action. The corrective actions were validated onsite by the surveyor on 4/11/2024 for F656. The facility is required to submit a Plan of Correction (POC). (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The findings include: Review of the facility's undated policy titled, Comprehensive Care Plan, showed .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .Other factors identified by the interdisciplinary team .will also be addressed in the plan of care .comprehensive care plan will describe .the following .Resident specific interventions that reflect the resident's needs . Review of the facility's policy titled, Abuse Prohibition/Investigative Policy, revised on 11/2016, showed . facility will prohibit abuse .The purpose of this policy is to ensure that the facility is doing all that is within its control to prevent occurrences of abuse .Prevention .Actions to prevent abuse .will include the following . Developing a care plan identifying appropriate intervention to prevent occurrences . Review of the facility's undated policy titled, Injury of Unknown Source, showed .The facility shall modify the resident's plan of care as needed to prevent recurrence or to stabilize, reduce, or remove underlying risk factors contributing to the injury . Resident #91 was admitted to the facility on [DATE] with diagnoses including COVID-19 and Vascular Dementia with Agitation. Review of the admission Minimum Data Set (MDS) assessment for Resident #91 dated 1/11/2024, showed Resident #91 had a Brief Interview for Mental Status (BIMS) of 3, which indicated severe cognitive impairment. Review of the INTERDISCIPLINARY TEAM CARE CONFERENCE NOTE/CARE PLANNING PROCESS for Resident #91 dated 1/11/2024, showed Resident #91 was .admitted to secure unit because of dementia with wandering behaviors .goes about the unit . Review of the care plan for Resident #91 dated 1/12/2024, showed, .impaired cognitive function/dementia . Administer medications as ordered. Observe/document for side effects and effectiveness . Review of the care plan for Resident #91 dated 1/20/2024, showed, .Abusive verbal attacks on staff and others . with no interventions in place. Review of the care plan for Resident #91 dated 1/22/2024, showed, .Behavior Care Plan .Potential for impaired or inappropriate behaviors related to Dementia .Administer medications as ordered. Observe/document for side effects and effectiveness .Provide program of activities that is of interest and accommodates residents [resident's] status . The resident's care plan did not have a person centered activity problem/program intervention. Continued review showed .Elopement Risk Care Plan . There were no interventions for this focus area on Resident #91's care plan. Resident #91's care plan did not include details of person centered activities of interest for Resident #91. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the Nursing Note for Resident #91 dated 3/30/2024 at 3:51 AM, showed, .Responded to CNA [Certified Nursing Assistant] #1 reporting that two residents were having altercation, upon arrival residents were separated, this resident [Resident #91] being nonaggressive, resident remained calm. resident noted to have four reddened scratch marks, three on the left cheek, and one above the left eyebrow. areas cleaned with NS [normal saline] resident removed away from harm. resident sitting close to the nurses' station at this time, has no complaints of pain or discomfort. NP [Nurse Practitioner], DON [Director of Nursing], and Family notified . Review of an Incident Report for Resident #91 dated 3/30/2024 at 4:00 AM, showed LPN #2 filled out an incident report for an incident involving Resident #91 in the 300 Hall outside of room [ROOM NUMBER]. Responded to CNA reporting that two residents were having altercation, upon arrival residents [Resident #91 and Resident #40] were separated, this resident [Resident #91] being non-aggressive, resident remained calm. resident noted to have four reddened scratch marks, three on the left cheek, one above the left eyebrow. areas cleaned with NS [normal saline]. resident removed away from harm. resident sitting close to the nurses station at this time, has no complaints of pain or discomfort. NP, DON, and Family notified . Immediate Action Taken .separated residents, removed resident from harm, assessed resident, cleaned area with NS. Contacted DON [Director of Nursing], NP [Nurse Practitioner], and family .Predisposing Physiological Factors .Confused .Impaired Memory .Predisposing Situation Factors .Wanderer .Witnesses . [CNA #1] . During an observation and interview on 4/1/2024 at 12:14 PM, Resident #91 wandered about the secure unit, LPN #1 was present in the dining room and did not offer any meaningful activities to redirect the resident from wandering. During an observation on 4/1/2024 at 12:30 PM, Resident #91 was observed wandering about the secure unit. Resident #91 was naked from the waist down and held a pair of pants in her hands. Registered Nurse (RN) #1 assisted Resident #91 to her room. Resident #91 returned to the hall with pants on and continued to wander about the unit. During an observation on 4/4/2024 at 8:52 AM, Resident #91 was observed walking towards the nurses' station with a package of candy in her hand and a piece in her mouth. RN#1 intervened and took the package of candy away from Resident #91. RN #1 stated the candy belonged to another resident. Resident #91 walked up to the desk and then walked down the back hall. Minutes after Resident #91 walked away from the nurse's station, a male resident was heard yelling for help. Resident #91 was observed standing at the foot of the male resident's bed. LPN #3 came down the hall from the nurses' station to take Resident #91 out of the male resident's room. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of hospital Discharge Documentation for Resident #40 dated 2/13/2024, showed Resident #40 was hospitalized from 1/26/2024 - 2/13/2024.pt [patient] from [named assisted living facility] involved in alleged altercation with another resident [at previous facility placement] and staff member. hx [history] dementia . Chief Complaint .Dementia, acute mental status change .aggression .History of Present Illness .past medical history of dementia .admitted in Senior Behavioral unit .because of her aggressive behavior and placement . patient is a resident .in memory care unit for the past 1 year and patient's cognition getting worse .and she was aggressive and she got hit on her neck and face and police was called and she was taken to emergency department .Patient's son reports that [named assisted living facility] will not take her back and she will need placement to another safe memory care facility .Patient's son reported she is paranoid and she thinks that somebody is going to kill her. She does get aggressive .Per patients attending nurse .patient has been very combative .The attending nurse reports that 3 nurses had been hurt by the patient as she has been punching and kicking nursing staff .Attending nurse reports that the patient is not rational and cannot explain her behaviors .Mental Status Exam .Patient is a little bit paranoid, judgment and insight impaired .Patient Discharge Condition .Stable for discharge .Discharge Disposition .Discharge Patient . Resident #40 was admitted to the secure unit at the facility on 2/13/2024 with diagnoses including Dementia with Other Behavioral Disturbance, and Depression. Review of an Abuse Screening Indicator for Resident #40 dated 2/13/2024, showed .Evaluate the resident in each of the FIVE (5) categories listed below. If you answered (Yes) to any of the questions, an abuse care plan should be initiated specific to the resident's risk factors . The category that asked .History of Abuse . (including physical .) .prior to admission . was answered .Undetermined . The category that stated .Factors that increase the residents vulnerability (e.g. [example] dementia, confusion, disorientation, poor insight/poor judgement, poor communication skills, poor ambulation or inability to ambulate/propel wheelchair, frailty/weakness, history of being exploited . was answered .YES . The category that stated History or presence of dysfunctional behavior (e.g. [example], provoking, aggressive, manipulative, derogatory, disrespectful, obnoxious, abhorrent, insensitive, attention-seeking, and/or otherwise abrasive/inappropriate behavior), including roaming/wandering into peers rooms/personal space . was answered .YES . Review of a Screening for Aggressive Behavior for Resident #40 dated 2/13/2024, showed .HISTORY OF ABUSE/NEGLECT EITHER AS A RECEIPIENT OR PERPETRATOR INCLUDING ABUSIVE AND/OR INAPPROPRIATE SEXUAL BEHAVIOR . was marked as a .MODERATE PROBLEM . Review of the admission MDS assessment for Resident #40 dated 2/20/2024, showed the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the care plan for Resident #40 dated 2/21/2024, showed, .Behavior Care Plan .has potential for impaired or inappropriate behaviors related to wandering, refusing medications, disrobing other patients . Administer medications as ordered .Anticipate and meet The resident's needs .Caregivers to provided opportunity for positive interaction, attention. Stop and talk with him/her as passing by .Explain all procedures to the resident before starting and allow the resident to adjust to changes .Observe for behavior episodes and attempt to determine the underlying cause . Continued review showed .impaired cognitive function/dementia or impaired thought processes r/t [related to] Dementia . Further review showed .has a communication problem r/t dementia with behaviors, sometimes understands .Be conscious of resident position when in groups, activities, dining room to promote proper communication with others . Continued review showed .Mood Care Plan .potential for mood state issues related to dementia with behaviors . The care plan did not address Resident #40's aggressive behavior or have interventions in place related to the aggressive behaviors. Review of a Nurse's Note for Resident #40 dated 3/7/2024 at 4:50 AM, showed, .showing increasing s/s [signs and symptoms] of agitation, with other residents, and staff called NP with new orders for [Ziprasidone (Geodon), an antipsychotic medication] 10mg [milligrams] via IM [intramuscular] injection one time only . contacted POA [power of attorney] .tolerated injection well . Review of NP Progress Note for Resident #40 dated 3/7/2024, showed, .Chief Complaint/Nature of Presenting Problem: Behavior follow up .I am seeing her today to follow up on agitation early this am [morning] .unable to be redirected .gave her an injection of [Ziprasidone] .she calmed down and went to sleep .Plan .address any behavioral related issues that may come up . Review of the NP Progress Note for Resident #40 dated 3/8/2024, showed, .Chief Complaint/Nature of Presenting Problem: Behavior follow up .I am seeing her today to follow up on aggitation [agitation] last night she was going from room to room taking other patient's items and nursing had a hard time getting her redirected .Diagnosis, Assessment and Plan .Moderate dementia with agitation .Adjustment disorder with anxiety .increase nighttime dose of Risperdal [antipsychotic medication] .and monitor behaviors . Review of an Incident Report dated 3/30/2024 at 4:00 AM, showed LPN #2 filled out an incident report for an incident involving Resident #91 in the 300 Hall outside of room [ROOM NUMBER]. It was noted .Responded to CNA reporting that two residents [Resident #91 and #40] were having altercation, upon arrival residents were separated, this resident being non-aggressive, resident remained calm. resident noted to have four reddened scratch marks, three on the left cheek, one above the left eyebrow. areas cleaned with NS. resident removed away from harm. resident sitting close to the nurses [nurses'] station at this time, has no complaints of pain or discomfort. NP, DON, and Family notified .Immediate Action Taken .separated residents, removed resident from harm .Predisposing Physiological Factors .Confused .Impaired Memory . Predisposing Situation Factors .Wanderer .Witnesses .[CNA #1] . Review of a Behavior Note for Resident #40 dated 3/30/2024 at 4:31 AM, showed, .Responded to CNA reporting that two residents were having altercation, upon arrival residents were separated, this resident [Resident #40] noted to be being aggressive with another resident [Resident #91], resident noted to have scratched another resident [Resident #91] in the face. separated, and redirected resident to residents room. Resident resting in bed at this time .NP, DON, and family aware . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a Nursing Note for Resident #40 dated 3/31/2024, showed, .Resident up wandering in and out of other residents' rooms. Taking other residents' clothes and wearing them. Resident becomes agitated and combative when attempting to retrieve the other resident's items. Resident finally settled down in her own bed after taking her evening medications . During an observation on 4/1/2024 at 10:10 AM, Resident #40 was in the resident's room. Resident #40 was pleasant at first, but when the room was entered the resident became agitated and stood in the doorway blocking the exit. The resident lifted her arm in preparation to hit the surveyor. A staff member assisted Resident #40 to step out of the doorway to allow screening to continue in other resident rooms. During an interview on 4/2/2024 at 2:46 PM, RN #1 (the secure unit supervisor) stated Resident #91 wandered about the unit. Resident #91 wandered into other resident's rooms and handles their personal belongings, and this made the other residents angry. RN #1 stated she was unaware if Resident #91 had any activity interventions to address the wandering behaviors. During an interview on 4/2/2024 at 3:41 PM, the DON stated she was made aware of the altercation between Residents #91 and #40 via (by way of) text message on 3/30/2024 around 4:00 AM from LPN #2. The DON stated the text message stated Resident #91 had scratches on her face from another resident. The DON confirmed Resident #91 was injured during the altercation and no new interventions were put in place to protect Resident #91 from further injury. During an interview on 4/5/2024 at 11:00 AM, the DON stated the care plans were being written by the MDS coordinator. The DON stated the process was changing and the Unit Managers, Social Services Director (SSD), and Activities Coordinator were supposed to be making the care plan updates and changes. The DON stated it was her expectation that unit managers would know what was on the care plan and be able to add interventions to the care plan as needed. The DON confirmed that new interventions were to be added to care plans after resident-to-resident altercation to protect the residents. The DON confirmed no new interventions had been added to Residents #91 and #40's care plans after the resident-to-resident altercation. During an interview on 4/6/2024 at 11:15 AM, the DON confirmed there were no interventions on Resident #91's care plan to address the resident's wandering around the secure unit and going into other resident rooms or taking items that did not belong to her. During an interview on 4/8/2024 at 8:37 AM, the SSD stated she was responsible for the behavioral care plan and revising the resident care plans after an altercation. The SSD was unaware of the altercation between Residents #91 and #40 on 3/30/2024 and had not revised the residents' care plans. Resident #24 was admitted to the facility on [DATE] with diagnoses including Lack of Coordination, Alzheimer's Disease, Dementia, Abnormalities of Gait and Mobility, and Muscle Weakness. Review of the comprehensive care plan for Resident #24 dated 8/22/2016, showed, .I have impaired cognitive function r/t Dementia . Review of the quarterly MDS assessment for Resident #24 dated 1/3/2024, showed the resident had a BIMS score of 3, which indicated the resident had severe cognitive impairment. Resident #24 exhibited no behavioral symptoms. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #73 was admitted to facility on 11/23/2022 and readmitted on [DATE] with diagnoses including Right Femur Fracture, Dementia, Abnormalities of Gait and Mobility, Lack of Coordination, Symptoms and Signs Involving Cognitive Functions and Awareness. Review of the care plan for Resident #73 dated 12/2/2022, showed, .impaired cognitive function/dementia or impaired thought processes r/t Dementia .communication problem r/t usually understands and usually makes self understood, dementia . Review of the annual MDS assessment for Resident #73 dated 11/30/2023, showed, the resident had a BIMS score of 4, which indicated the resident had severe cognitive impairment. Resident #73 exhibited no behavioral symptoms. Review of facility documentation and Residents #24 and #73's medical record showed there was a resident-to-resident altercation in the residents' room (the residents were roommates) on 2/9/2024. The residents were observed .open hand slapping each other . due to Resident #24 .getting in . and trying to remove clothes from Resident #73's closet. Both residents were injured during the altercation. Resident #24 sustained an abrasion on top of the scalp, bruising at the bridge of the nose, and fading redness to the face and Resident #73 sustained a bruise to the bridge of the nose. Resident #24 was moved to another room after the altercation and Safety Checks were conducted every 15 minutes for 24 hours after the incident. Review of the care plan for Resident #24 showed the care plan did not address the resident-to-resident altercation on 2/9/2024 and no interventions were in place related to the altercation or potential for abuse of other residents. Review of the care plan for Resident #73 showed the care plan did not address the resident-to-resident altercation on 2/9/2024 and no interventions were in place related to the altercation or potential for abuse of other residents. During an interview on 4/6/2024 at 10:58 AM, the DON stated resident care plans were to be developed and implemented after resident-to-resident altercations with interventions to protect the residents from further abuse. The DON confirmed Residents #24 and #73's care plans had not been developed to include the resident-to-resident altercation and no new interventions had been implemented to protect the residents. Resident #44 was admitted to the facility on [DATE] with diagnoses including Dementia, Generalized Anxiety Disorder and Hypertension. Review of the care plan for Resident #44 dated 11/10/2020 and revised on 11/16/2021, showed, .impaired cognitive function r/t [related to] my Dementia .history of Paranoia and hallucinations .may misunderstand others r/t my confusion . Interventions included the staff was to provide the resident with cues/redirection daily as needed.Behavior Care Plan .Potential for impaired or inappropriate behaviors related to delusions and hallucinations . with interventions including .Administer medications as ordered. Observe/document for side effects and effectiveness .Observe behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes . (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the annual MDS assessment for Resident #44 dated 11/16/2023, showed the resident had a BIMS of 12, which indicated the resident had moderate cognitive impairment. Resident #44 exhibited no behavioral symptoms. Review of the NP Progress Note for Resident #44, dated 2/12/2024 at 8:44 AM, showed NP #1 followed up with Resident #44 after an altercation (2/11/2024) with another resident (Resident #46).Chief Complaint/Nature of Presenting Problem: Follow up on encounter with another resident .She likes to sit in or near her doorway in the hallway. Last night she was sitting there speaking with another resident when a confused resident (Resident #46) came and attempted to get into her room. According to [Resident #44] they had a verbal exchange and he [Resident #46] attempted to hit her [Resident #44] and in the exchange she accidently scratched him with her fingernail. She denies injury and the other resident has been moved to another hall. She tells me he accused her of attacking him however she was just attempting to defend herself .Physical Exam .Psychiatric: Calm .Diagnosis, Assessment and Plan .Continue to monitor for signs of latent injury. The other resident [Resident #46] has been moved and she [Resident #44] is call [calm] and in no distress . During an interview on 4/8/2024 at 12:03 PM, Resident #44 stated a man came to her room, tried to get into the room, and she did not want him in the room. Resident #44 stated the man kept pushing at her trying to get in her room. Resident #44 stated there was no physical contact made. The resident stated .he finally went on his way, but he is still here [in the facility] .Everyone seems to be more upset about it than I am . Review of the care plan for Resident #44 showed the care plan did not address the resident-to-resident altercation which occurred on 2/11/2024. Resident #46 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Dementia, With Psychotic Disturbance and Anxiety Disorder. Review of the care plan for Resident #46 dated 2/21/2023, showed .[resident has] communication problem r/t Hearing deficit, Encephalopathy .Potential for alteration in psycho-social well being .and at times .get lonely and depressed . The care plan was revised 4/13/2023 and showed .[resident] has hallucinations .will state that .see my dead wife .will state that I know the staff or others can see her . with a revised target of . Hallucinations will not interfere with my daily routine . Review of the annual MDS assessment for Resident #46 dated 2/3/2024, showed the resident had a BIMS of 11, which indicated the resident had moderate cognitive impairment. Resident #46 exhibited no behavioral symptoms. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the NP Progress Note for Resident #46 dated 2/12/2024 at 8:58 AM, showed NP #1 saw the resident after an altercation between Resident #44 and Resident #46. It was noted .Chief Complaint/Nature of Presenting Problem: Abrasion left eye and right forearm .advanced dementia and psychosis .He often has delusions of seeing his dead wife and sometimes searches forher [for her]. Last p.m. he [Resident #46] was coming down the hallway and attempting to go into another resident's room .When the other resident [Resident #44] who also has dementia attempted to stop him there was an exchange between the 2 and he [Resident #46] got scratched by her [Resident #44] fingernails. He has a very small abrasion underneath his left eye and a larger abrasion on his right inner forearm. He has been moved to another unit and this morning he is lying in bed and calm. He does remember the exchange and tells me that woman tried to stop me from going in that room he does not seem to understand that the room he was entering was not a common area . Physical Exam .Skin .Approximate 1 cm [centimeter] abrasion below the left eye there is no bleeding it does appear infected and he is able to see out of this eye .Approximate 4 cm [centimeters] x 2 cm abrasion on right forearm appears somewhat superficial there is no redness or drainage noted and no swelling . Psychiatric .Alert, he is calm at present and resting in bed in no distress .Diagnosis and Assessment . Abrasion, face w/o [without] infection .Abrasion of right upper extremity .Plan: Clean abrasions with warm soapy water and rinse and pat dry. apply triple antibiotic daily, place non-stick covering over arm abrasion and wrap with clean dry dressing daily . Review of the care plan for Resident #46 showed the care plan did not address the resident-to-resident altercation which occurred on 2/11/2024. Resident #39 was admitted to the facility on [DATE] with diagnoses including Dementia, Abnormal Gait and Mobility, and Maltreatment. Review of a History and Physical for Resident #39 dated 5/31/2022, showed non ambulatory and unable to sit in a wheelchair due to leg contractures. Review of a History and Physical for Resident #39 dated 12/21/2023, showed Resident #39 presented to the hospital with left knee pain. Radiology views showed the resident had an impacted left distal femur fracture. Review of the quarterly MDS assessment dated [DATE], showed Resident #39 had a BIMS of 7, which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan for Resident #39 dated 3/3/2024, showed, .ADL [activities of daily living] self-care performance deficit r/t weakness, dementia .require assist x [times] 2 staff members to safely transfer .range of motion limitation to .bilat [bilateral or both] lower extremities .at risk for falls related to weakness, dementia . The care plan did not reflect the left femur fracture and no interventions had been implemented related to the fracture. During an interview on 4/9/2024 at 4:20 PM, the DON stated it was her expectation that a resident's care plan was updated after any incident including resident-to-resident altercation or a fracture. The DON confirmed Residents #44 and #46 had no care plan for the incident on 2/11/2024 and Resident #39 had no care plan for the fracture. Resident #20 was admitted to the facility on [DATE] from the hospital with diagnoses including Lack of Coordination, Intellectual Disabilities, Major Depressive Disorder, and Anxiety Disorder. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of a behavior note for Resident #20 dated 2/19/2024, showed, .note [noted] to be visibly agitated walking up hallway near room. Resident went into dayroom A turned over 4 chairs and turned over trash can . states 'someone took my blankets' . Review of the care plan for Resident #20 initiated on 11/16/2022 and last revised on 4/5/2024, showed the care plan had not been developed to address the aggressive physical behaviors and throwing chairs as documented in an event on 2/19/2024. Review of a quarterly MDS assessment for Resident #20 dated 2/23/2024, showed the resident had a BIMS score of 8, which indicated the resident had moderate cognitive impairment . Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Mild Neurocognitive Disorder, Post Traumatic Stress Disorder (PTSD), Nightmare Disorder, Anxiety, and Depression. Review of a HISTORY AND PHYSICAL for Resident #78 dated 4/3/2023, showed, . DIAGNOSIS/ASSESSMENT/PLAN .Dementia with behavior disturbance/PTSD . Depression: citalopram [antidepressant medication] 20 mg [milligram] PO [per oral/by mouth] daily .Anxiety: buspar [antianxiety medication] 10 mg PO TID [three times a day] . Review of the mental health progress notes for Resident #78 dated 4/19/2023 and 4/27/2023, both showed, . DX [diagnosis] .GAD [Generalized Anxiety Disorder], MDD [Major Depressive Disorder] . Review of a Psychotherapy Progress Note for Resident #78 dated 2/13/2024, showed, .Prognosis & Progress .Resident will require ongoing talk therapy due to his history of PTSD, anxiety, depression and dementia . Review of the care plan for Resident #78 initiated on 4/1/2023 and last revised on 2/20/2024, showed the resident's active diagnoses of anxiety and depression were not addressed on the care plan and no interventions had been implemented. During an interview on 4/3/2024 at 8:45 AM, the DON confirmed Resident #78's care plan did not include a care plan for depression or anxiety. The DON confirmed Resident #78's diagnoses of depression and anxiety should have been addressed on his care plan and included person-centered interventions. During a telephone interview on 4/5/2024 at 2:34 PM, the Regional Remote MDS Coordinator stated care plans were to be developed/updated after each MDS assessment. The Regional Remote MDS Coordinator confirmed Resident #78's care plan should have included his diagnoses of depression and anxiety. (continued on next page)

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F 0656 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/9/2024 at 4:29 PM, the DON and the Administrator addressed what staff member was responsible for creating care plans. The DON stated the MDS Coordinator was previously responsible for developing and revising care plans. The facility did not currently have an on-site MDS Coordinator was using an offsite MDS Coordinator that was responsible for developing care plans based off the MDS assessment. The sections of the MDS assessment that required in-person evaluation had been designated to specific staff members in the facility. The DON confirmed no one had taken responsibility for revising care plans since the MDS Coordinator left. It was the DON's expectation that the SSD developed and revised the behavioral care plan with the Interdisciplinary Team's input. The MDS Coordinator left the facility 2/2024 and the facility had not identified anyone that was ultimately responsible for the care plans. The SSD was responsible for behavioral care p [TRUNCATED]

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45837 Based on facility policy review, medical record review, observation and interview, the facility failed to provide nail care during Activities of Daily Living (ADL) care for 1 resident (Resident #7) of 31 residents reviewed for ADL care. The findings include: Review of the facility's undated policy titled ADL CARE (Nails), showed .policy will provide the facility with guidance related to provision of care to resident's [residents'] nails for good grooming and health .nursing staff will provide routine cleaning and inspection of nails during ADL care on an ongoing basis . Resident #7 was admitted to the facility on [DATE] with diagnoses including Alzheimer's Disease, and Cerebral Infarction. Review of a care plan for Resident #7 dated 11/29/2022, showed .[resident] has an ADL self-care performance deficit r/t weakness, LBKA [left below the knee amputation] .with interventions of .resident requires extensive assistance .with personal hygiene . Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #7 was cognitively intact. Review of a Care Log for Resident #7 dated 3/2024, showed the resident had received baths twice a week in the month of 3/2024. Review of an ADL sheet for Resident #7 showed the resident last received a bath on 3/30/2024. During an observation on 4/1/2024 at 11:17 AM, Resident #7 was resting in bed and his fingernails were visibly dirty. The resident stated he wanted to have his nails cleaned. During an observation and interview on 4/1/2024 at 11:23 AM, Licensed Practical Nurse (LPN) #5 confirmed the resident had really dirty fingernails on both hands. During an observation on 4/2/2024 at 2:22 PM, Resident #7 was in bed resting and had dirty fingernails. During an observation on 4/3/2024 at 9:58 AM, Resident #7 was in bed resting and had dirty fingernails. During an interview on 4/3/2024 at 3:35 PM, the Director of Nursing (DON) stated she expected nursing to keep the residents' nails clean, and that it should have been completed during ADL care or showers as the policy stated.

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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** 41291 Based on facility policy review, medical record review, and interview, the facility failed to identify and complete a fall investigation for 1 Resident (#39) of 7 residents reviewed for falls. The findings include: Review of the facility's undated policy titled, Unusual Occurrences, showed .Unusual occurrences may include .Fall incident .The Nurse will .Assess the resident's condition .Notify the physician .Notify the resident's representative .Notify DON [Director of Nursing]/Administrator .Document in the nurse's note . Review of the facility's undated policy titled, Fall Prevention & Management Program, showed .A fall is an event in which an individual unintentionally comes to rest on the ground, floor, or other level .The event may be witnessed, reported, or presumed .A near miss .is also considered a fall .When .resident experiences a fall, the facility will .Assess the resident .Complete a post-fall assessment .an incident report .Notify physician .family .Review the resident's care plan .update as indicated .Document .assessments .actions .Obtain witness statements . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, showed .Residents have the right to be free from abuse .Provide staff .training .that include . identification .reporting of abuse .Identify .investigate all possible incidents of abuse .report any allegations within timeframes required by federal requirements .Protect residents from any further harm .implement a QAPI review .analysis of report, allegations .findings of abuse . Resident #39 was admitted to the facility on [DATE] with diagnoses including Dementia, Abnormal Gait, and Mobility, and Maltreatment. Review of a History and Physical for Resident #39 dated 5/31/2022, showed non ambulatory and unable to sit in a wheelchair due to leg (bilateral) contractures. Review of a quarterly [NAME] Data Set (MDS) assessment dated [DATE], showed Resident #39 had severe cognitive impairment and required substantial/maximal assistance with mobility. Review of a nursing progress note for Resident #39 dated 12/20/2023, showed .CNA reported to nurse . resident .verbalizing pain upon movement in bed .requesting to go to ER [emergency room]. Resident assessed .Alert and Orientated x3. Bilateral chest expansion noted. Skin turgor good. Abdomen soft and non-distended. Resident verbalizing pain in right leg .leg .swollen to up to right hip .+2 pitting edema in Right foot .Bilateral pedal pulses are noted .Capillary refill is WNL [within normal limits] bilateral. Resident vocalizes pain to touch BLE [bilateral lower extremities]. Vitals are WNL DON notified. Awaiting EMS [Emergency Medical Service] for transport to ER . Review of a hospital radiology report for Resident #39 dated 12/21/2023, showed osteopenia with a left femur fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a History and Physical for Resident #39 dated 12/21/2023, showed the resident presented to the hospital with left knee pain. The resident reported facility staff were transferring her to the shower when they dropped her. Review of a Orthopedic Consult Note for Resident #39 dated 12/21/2023, showed upon physical examination the left distal femur had soft tissue swelling with tenderness to the left distal femur region. The case was reviewed and discussed with consideration of Resident #39's comorbidities; .may consider speaking with guardian of the possibility and benefit of above the knee amputation. The likelihood of the fracture healing is low . Review of a medical record for Resident #39 showed no incident report or investigation had been completed to determine a root cause analysis for the confirmed left femur fracture. During an interview on 4/1/2023 at 4:00 PM, Resident #39 stated 2 Certified Nursing Assistants (CNA) (unknown by resident) were getting her up for a shower and dropped her (unsure of date). She stated the CNAs during the transfer from her bed to the shower chair, asked her to put some weight on her legs and she told them she couldn't stand. She further stated the 2 CNAs then put her on the floor on her knees and yelled for assistance. The resident stated she was sent to the hospital, .my leg was broke .they [hospital] wanted to cut my leg off .I refused . Resident #39 stated she had been bedbound and non-ambulatory for years. Interviews on 4/2/2024 at 8:40 AM, 9:00 AM, and 3:00 PM, Resident #39 repeated the same recollection of events. During a telephone interview on 4/3/2024 at 7:48 PM, CNA #5 stated she and Nurse Aide trainee (NA #1) went to get Resident #39 up for a shower. While transferring the resident to the shower chair, she had to be lowered to the floor; .we assisted her to the floor . She [CNA] stated Resident #39 is very contracted, and when they lowered her to the floor, the resident's knee did touch the floor. The Licensed Practical Nurse (LPN #5) and another staff member came to room to assist getting Resident #39 out of the floor. LPN #5 assessed the resident, and the resident did not complain of pain. CNA #5 stated she thought an incident report was completed by LPN #5, and she [CNA] provided a witness statement when the DON asked her about the incident. During a telephone interview on 4/3/2024 at 8:10 PM, LPN #6 stated she sent Resident #39 out to the hospital on 12/20/2023, when the resident complained of right leg pain and swelling. The LPN notified the Nurse Practitioner (NP) and the DON the resident reported she had fallen about a week ago (12/11/2023) and complained of right leg pain and swelling. LPN #6 stated she had not received a shift report Resident #39 had suffered a fall or injury. LPN #6 confirmed she did not complete an incident report. During a telephone interview on 4/3/2024 at 8:13 PM, NA #1 stated Resident #39 had bilateral lower extremity (BLE) contractures and was a total maximum assist with transfers. She assisted CNA #5 with Resident #39's transfer from the bed to the shower chair on 12/11/2023, when they lowered the resident to the floor. LPN #5 assessed the resident, with no injuries, no complaints of pain, and assisted with getting the resident up from the floor. NA #1 further stated she is unsure if an incident report was completed and informed she had been asked to write a witness statement for the DON. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 10:07 AM, CNA #6 stated Resident #39 was admitted to the facility with severe BLE contractures. She stated she was not caring for the resident when the resident was lowered to the floor (unknown date) but did assist with getting the resident out of the floor. She entered the room when called for assistance to get the resident out of the floor. When she entered the room Resident #39 was being supported by 2 CNAs on her knees (both), LPN #5 was present in the resident's room, assessed the resident and all of them assisted Resident #39 off the floor; the resident did not have any injuries and did not complain of pain. CNA #6 stated Resident #39 normally had swelling of the knees. CNA #6 was unaware if an incident report had been completed. During an interview on 4/4/2024 at 10:25 AM, Registered Nurse (RN #6) stated she was the unit supervisor and was made aware of Resident #39's fracture on 12/21/2023, after the resident had been admitted to the hospital. She stated Resident #39 was non weight bearing and was a 2-person maximum assist with transfers. RN #6 stated she was unaware if Resident #39 having new swelling; .her bilateral lower extremities were always swollen . During a telephone interview on 4/4/2024 at 10:31 AM, LPN #5 stated he was the nurse on duty on 12/11/2023 when Resident #39 was lowered to the floor by CNA #5 and NA #1 during a transfer to the shower chair. He stated the resident did not have a fall. CNA #5 and NA #1 realized they could not support Resident #39 during the transfer, and she was lowered to the floor. The LPN assessed the resident, there was no obvious injury, and the resident did not complain of pain during or after the assessment. LPN #5 stated he did not complete an incident report; the resident .did not have an actual fall .was only lowered to the floor . He stated after Resident #39 was sent out to the hospital (on 12/20/2023-9 days after the fall) and was diagnosed with a fracture he was interviewed by RN #6 and the DON. He further stated if he had thought Resident #39 was injured or hurt in any way, he would have notified the provider and asked for her to be sent out for evaluation and x-rays. During an interview on 4/4/2024 at 4:50 PM, the DON stated Resident #39's fracture was brought to her attention on 12/21/2023, after being sent to the hospital and x-rays confirmed the left femur fracture. There was no incident report completed and staff interviews were the only investigation conducted. The DON stated the incident was not a reportable event. When the DON was asked if the incident met the definition of an injury of unknown origin; she stated, .I didn't think about that . A formal investigation nor a root cause analysis to determine the cause of the fracture had been conducted. The DON confirmed the fall incident (on 12/11/2023) had not been reported by the staff, an incident report had not been completed, and a thorough investigation to determine the root cause of the fracture was not done. (continued on next page)

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	445292	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/5/2024 at 10:55 AM, the Administrator stated she was aware Resident #39 had been sent to the hospital and identified with a fracture, staff interviews were conducted, and it was determined at an earlier date (12/11/2023), staff had lowered the resident to the floor during an assisted transfer. There was no incident report, but an investigation was started by the DON. The investigation only consisted of staff interviews. She stated a root cause analysis meeting was not held. Her determination of the root cause of the fracture was based solely on staff interviews. The Administrator stated she was the Abuse Coordinator for the facility, and there was no discussion Resident #39's fracture could have possibly been identified as an injury of unknow origin due to the time lapse from the date the resident was lowered to the floor (12/11/2023) and the date the resident experienced lower extremity swelling and pain and was sent to the ED, where a fracture was identified (12/20/2023-9 days later). The Administrator stated she was aware serious physical harm was reportable to regulatory agencies, but she was able to determine within 2 hours the cause of the injury, from staff interviews was transfer technique by the staff. The Administrator stated she met with the Director of Therapy, and an in-service on proper transfer techniques with use of gait belt was initiated on 12/21/2023 at 2:00 PM with the nursing staff and continued until all staff were educated. The Administrator confirmed the facility did not follow their policies for identifying, investigating, and reporting falls or injuries of unknown origin.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Post nurse staffing information every day. 45837 Based on facility policy review, observation, and interview, the facility failed to post accurate staffing information to reflect daily staffing levels on 7 days of 31 days reviewed for staffing. The findings include: Review of the facility's undated policy titled Staffing Posting Guidelines, showed .provide staffing information to the residents, visitors and staff .posting will include .current date .Total numbers of hours worked by the following categories of licensed and unlicensed nursing staff .RN's [Registered Nurses] .LPN's [Licensed Practical Nurses] .CNA's [Certified Nursing Assistants] .Administrator will designate a person to ensure updated information is entered into the staffing worksheet and posted in the lobby/entrance area . Administrator will designate a back-up person to ensure .documentation is posted .designated person(s) will ensure that the document includes accurate information . During an observation on 4/1/2024 at 8:35 AM, the daily nurse staffing information posted in the lobby was the staff scheduled for 3/28/2024 and had not been updated to reflect the current staff in the facility on 4/1/2024. Review of the daily nurse staffing sheet compared to the actual time punches from 3/16/2024-3/29/2024 showed inconsistencies on 6 days reviewed as follows: 3/17/2024 from 6:00 PM to 6:00 AM, 6 CNAs scheduled and 4 CNAs actually worked 3/18/2024 from 6:00 PM to 6:00 AM, 5 CNAs scheduled and 3 CNAs actually worked 3/22/2024 from 6:00 PM to 6:00 AM, 6 CNAs scheduled and 5 CNAs actually worked 3/24/2024 from 6:00 PM to 6:00 AM, 6 CNAs scheduled and 5 CNAs actually worked 3/27/2024 from 6:00 PM to 6:00 AM, 4 LPNs scheduled and 3 CNAs actually worked 3/31/2024 from 6:00 PM to 6:00 AM, 6 CNAs scheduled and 4 CNAs actually worked During an interview on 4/4/2024 at 2:11 PM, the Scheduler stated it was her responsibility to post daily staffing information in the lobby. If there was a change or call-in, a floor nurse would make the change manually. The Scheduler confirmed the daily nurse staffing information posted on 4/1/2024 was dated 3/28/2024 and the correct posting had not been displayed since 3/28/2024. The Scheduler confirmed that the staff postings for 3/17/2024, 3/18/2024, 3/22/2024, 3/24/2024, 3/27/2024 and 3/31/2024 had inconsistencies in staff numbers and was inaccurate.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, observation, and interview, the facility failed to develop a Dementia care plan for 1 resident (Resident #84) of 9 residents reviewed for Dementia Care. The findings include: Review of the facility's undated policy titled, Dementia Care, showed .The facility will .develop, and implement care plans through an interdisciplinary team (IDT) approach . Resident #84 was admitted to the facility on [DATE] with diagnoses including Dementia, Lack of Coordination, and Bipolar Disorder. Review of a History and Physical for Resident #84 dated 1/29/2024, showed .Past Medical History .Vascular dementia . Review of an admission Minimum Data Set (MDS) assessment dated [DATE], showed Resident #84 was cognitively intact. Resident #84 exhibited no behavioral symptoms. Active diagnoses included Non-Alzheimer's Dementia. Review of the comprehensive care plan for Resident #84 showed the resident was not care planned for Dementia. Review of the medical record for Resident #84 dated 2/15/2024, showed an order for Aricept (a medication for dementia used to help improve attention, memory and behaviors) 10 milligrams (mg) by mouth daily at bedtime for Dementia. During observations from 4/1/2024 - 4/3/2024, no concerns were observed related to the resident's behaviors or Dementia diagnosis. During an interview on 4/3/2024 at 4:11 PM, the Director of Nursing confirmed the resident had a diagnosis of dementia and Resident #84's care plan did not have a dementia care plan. The DON stated Resident #84's care plan should have included a care plan with person-centered interventions for the resident's diagnosis of dementia. During a telephone interview on 4/3/2024 at 2:34 PM, the Regional Remote MDS Coordinator stated care plans were developed by the MDS Coordinator after the completion of the MDS assessment. The Regional Remote MDS Coordinator confirmed Resident #84's admission MDS assessment showed an active diagnosis of Dementia and should have been care planned. The Interdisciplinary Team (IDT) should have implemented person-centered interventions for the resident's diagnosis of Dementia. Interviews with staff assigned to the resident from 4/1/2024 - 4/3/2024 revealed the resident did not display any behavioral symptoms related to his Dementia diagnosis and were aware of non-pharmacological approaches for behaviors.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, medical record review, and interview, the facility failed to ensure the physician or nurse practitioner acted upon a recommendation from the consultant pharmacist for 1 resident (Resident #27) of 5 residents reviewed for unnecessary medications. The findings include: Review of the facility's undated policy titled, Medication Regimen Review, showed .The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed .The pharmacist shall document either that no irregularity was identified irregularities .The pharmacist shall communicate any irregularities to the facility in the following ways .Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs .Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing .The pharmacist shall communicate any recommendations and identified irregularities via written communication within 10 working days of the review .The facility staff will address the recommendation according to procedures for addressing medication regimen review irregularities . Resident #27 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Osteoarthritis, Dementia, Psychosis, Chronic Kidney Disease, Renal Insufficiency, and Restless Leg Syndrome. Review of a comprehensive care plan for Resident #27 showed altered bladder elimination, urinary incontinence, and kidney disease. Review of a physician order for Resident #27 dated 4/23/2022, showed Oxybutynin Chloride (medication used to treat over active bladder) 5 milligrams (mg) by mouth daily for Chronic Kidney Disease. Review of a Consultant Pharmacist Communication to the Physician for Resident #27 dated 1/27/2024, showed .Review Period: Jan [January 2024 .COMMUNICATION/RECOMMENDATION .QUALITY INDICATOR: POTENTIALLY INAPPROPRIATE DRUG .Oxybutynin .5mg po q [every]AM [morning] . Oxybutynin .is not recommended for use in patients > [greater than] 65 due to increased sedation and anticholinergic effects in the elderly .Oxybutynin use has also been associated with an increased risk of new onset dementia .With this in mind, please consider the following .DC [discontinue] Oxybutynin . The communication included alternative medications with check boxes to indicate if the medication was to be changed to one of the alternate options. The recommendation was not acknowledged by the physician or nurse practitioner. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #27 had moderate cognitive impairment and was always incontinent of bladder. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/4/2024 at 11:07 AM, the Director of Nursing (DON) confirmed no rationale for the rejection of the pharmacy consultant's recommendation had been documented on 1/27/2024 and a rationale should have been documented when a recommendation was rejected. During an interview on 4/4/2024 at 2:59 PM, the DON stated the consultant pharmacist's recommendations were emailed to the DON and the DON placed them Nurse Practitioner (NP) #1's box to address. The DON confirmed the resident's pharmacy recommendation drug regimen review dated 1/27/2024 had not been addressed by the nurse practitioner or the physician. The DON stated, .I'm not sure what happened .I guess it just got missed . The DON confirmed all pharmacy recommendations were to be addressed by the NP or physician. During a telephone interview on 4/4/2024 at 3:50 PM, NP #1 stated the process on pharmacy recommendations were as followed: the DON would place pharmacy recommendations in her in box, she acknowledged and addressed the recommendation. The acknowledged pharmacy recommendation would go to medical records to be scanned into the resident's medical record. NP #1 stated she did not recall seeing the pharmacy consultant's recommendation for Resident #27 dated 1/27/2024. NP #1 stated she would not have discontinued or changed the medication if she had seen the recommendation and had no concerns related to the resident taking the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50216 Based on facility policy review, medical record review, observation, and interview, the facility failed to ensure the medication error was less than 5 percent. There were 26 opportunities with 2 errors resulting in a 7.69% medication error rate. The errors involved 2 of 8 residents (Residents #20 and #92) in the sample. The findings include: Review of the facility's undated policy titled, MDI [Metered Dose Inhaler] Administration guidelines, showed . Instruct resident to exhale fully .to hold breathe and slowly count to ten .to slowly exhale through pursed lips . Repeat puffs as directed, waiting at least 1 (one) minute between puffs, or per manufacturer's specification . Review of the facility's undated policy titled, Medication Error Guidelines, showed .ensuring residents receive care and services safely in an environment free of .medication errors .'Medication error' means the observed or identified preparation or administration of medications .which is not is accordance with the prescriber's orders; manufacturer's specifications .'Medication error rate' is determined by calculating the percentage of errors observed during a medication administration observation .nurses shall ensure medications will be administered .According to physician's orders .Per manufacturer's specifications regarding the preparation . administration .prevent medication errors .ensure safe medication administration, nurses should verify .Right medication .administration .If a medication error occurs .nurse .notifies the physician or health care practitioner as soon as possible . Resident #20 was admitted to the facility on [DATE] with diagnoses including Diabetes Mellitus Type 2, Intellectual Disabilities, Major Depressive Disorder, and Anxiety. Review of a Physician Order Summary Report for Resident #20 dated 4/2024, showed .Albuterol Sulfate [a medication used to treat breathing difficulties] 2 puff inhale orally three times a day .Acute Bronchitis . During an observation and interview on 4/2/2024 at 2:18 PM, Licensed Practical Nurse (LPN) #1 prepared an albuterol inhaler for Resident #20. LPN #1 failed to instruct Resident #20 to inhale and exhale prior to the inhalation of the medication, administered a second puff into the resident's mouth, and had not waited the required 1 minute between puffs. LPN #1 confirmed .I didn't wait a minute between the puff . During an interview on 4/8/2024 at 4:22 PM, the Director of Nursing (DON) confirmed LPN #1 should have followed the manufacturer's guidelines and physician orders when administrating inhalers. 41291 Resident #92 was admitted to the facility on [DATE] with diagnoses including Metabolic Encephalopathy, Heart Failure, Atherosclerotic Heart Disease, and Altered Mental Status. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Medication Administration Record for Resident #92 dated 4/2023, showed administered: Potassium Chloride 20 MEQ (milliequivalent) 1 tablet by mouth one time a day for hypokalemia, administration time scheduled for 7:00 AM. During a medication administration observation on 4/2/2024 at 9:00 AM, LPN #7 prepared and administered Potassium 20 MEQ to Resident #92 (1 hour late). During an interview on 4/2/2024 at 9:05 AM, LPN #7 she comes in at 8:00 AM, and by the time she arrives some of the resident's medications are already late. She stated the DON was aware medications are being administered late on the days she was scheduled to work at 8:00 AM. During an interview on 4/4/2024 at 5:00 PM, the DON stated it was her expectation for the unit manager to administer 7:00 AM medications until LPN #7 arrived to work at 8:00 AM and confirmed the 7:00 AM medication for Resident #92 were administered late.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, job description review, facility documentation review, medical record review, and interview, the facility's Administration failed to provide effective leadership and oversight to ensure effective systems were in place to ensure residents were free from abuse, identify serious outcomes related to abuse, investigate allegations of abuse, determine a root cause analysis (RCA) for abuse, develop and implement person centered care plans, report allegations of abuse to the local and state designated authorities, and discuss concerns related to abuse in Quality Assurance Performance Improvement (QAPI) and Governing Body (GB) meetings. The facility's Administration failed to ensure staff were educated and knowledgeable to recognize resident to resident altercations could lead to abuse regardless of cognitive status, injury of unknown origin as potential abuse, and to maintain an effective QAPI program placed 7 Residents (#39, #91, #40, #24, #73, #46, and #44), in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The facility's failure to maintain an effective Administration to identify resident to resident altercations and an injury of unknown origin as potential abuse, and ensure incidents are investigated, and reported had the potential or likelihood to impact all 101 residents of the facility. The Administrator, Director of Nursing (DON), [NAME] President (VP) of Regulatory Compliance and QAPI Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-835 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited Immediate Jeopardy at F-835 at a scope and severity of K. An Extended survey was conducted onsite from 4/10/2024 and 4/11/2024. The IJ began on 12/21/2023 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/10/2024 for F-835. The corrective actions were validated on site by the surveyors on 4/11/2024 for F-835. Noncompliance continues at F-835 at a scope and severity of E. The facility is required to submit a Plan of Correction (POC). The findings include: (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Injury of Unknown Source, showed .This policy will provide guidelines related to unexplainable injuries .Any observed unexplained injuries shall be reported to the resident's nurse .The attending physician/Nurse practitioner notification will be completed .if the injury is of unknown source, reporting .procedures shall be implemented in accordance with the facility's abuse policy and procedures .An injury should be classified as an 'injury of unknown source' when .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of .the extent of the injury . Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised on 4/2014, showed .The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements . Review of the Director of Nursing's Job Description signed and dated by the DON on 4/23/2019, showed . The Director of Nursing's duties and responsibilities include planning, organizing, developing, and directing all nursing policies and procedures in accordance with current federal, state, and local standards, guidelines, and regulations governing this facility and as directed by the Administrator . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, showed .Residents have the right to be free from abuse .This includes .physical abuse . Protect residents from abuse .by anyone including .other residents .Establish .maintain a culture of compassion .caring for all residents .particularly those with behavioral, cognitive or emotional problems . Provide staff .training .that include .identification .reporting of abuse .handling .physically aggressive resident behavior .Implement measures to address factors that may lead to abusive situations .Identify .investigate all possible incidents of abuse .report any allegations within timeframes required by federal requirements. Protect residents from any further harm .QAPI review and analysis of reports, allegations .findings of abuse . Review of the Administrator's Job Description signed and dated by the Administrator on 10/13/2023, showed . The duties and responsibilities of the Administrator include supervising all aspects of facility operation in accordance with current federal, state, local standards, guidelines, and regulations governing the facility and as directed by the Board of Directors . Review of the facility's assessment dated [DATE], showed the facility admission process and continuing care decisions are reviewed by Administration. Any staff education needed prior to the resident's admission or identified after admission will be conducted by Nursing Administration. The facility identified the need to provide services and general care based on resident's needs which included mobility and fall/fall with injury prevention, mental health and behavior management, and provide person-centered care. Staff training, education, and competencies included Abuse training that addressed care management for persons with dementia and resident abuse prevention. Resident #39 was admitted to the facility on [DATE] with diagnoses including Abnormal Mobility, Maltreatment, with severe cognitive impairment, and bilateral lower extremities contractures. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #39's nursing progress note dated 12/20/2023, showed .CNA reported to nurse .resident .verbalizing pain upon movement in bed .requesting to go to ER [emergency room] .Resident verbalizing pain in right leg .leg .swollen to up to right hip .+2 pitting edema in Right foot .Bilateral pedal pulses are noted .Resident vocalizes pain to touch BLE [bilateral lower extremities] .DON notified. Awaiting EMS [emergency medical service] for transport to ER . Review of Resident #39's hospital radiology reports dated 12/21/2023, showed Resident #39 had osteopenia with a left femur fracture. During an interview on 4/4/2024 at 4:50 PM, the DON stated Resident #39's fracture was brought to her attention on 12/21/2023, after being sent to the hospital and x-rays confirmed the left femur fracture. There was no incident report. The DON stated the investigation only included staff interviews. The DON stated she was unable to interview Resident #39 until 12/26/2023; after the resident returned from the hospital (6 days after the fracture was identified). The DON stated the incident was not a reportable event. When the DON was asked if the incident met the definition of an injury of unknown origin; she stated, I didn't think about that. She confirmed a thorough investigation to determine the root cause of the fracture was not completed. During an interview on 4/5/2024 at 10:55 AM, the Administrator stated she was aware Resident #39 had been sent to the hospital and identified with a fracture on 12/21/2023. Staff interviews were conducted by the DON after she and the DON were notified of Resident #39's fracture. The Administrator stated a root cause analysis meeting was not held and her determination of the root cause of the fracture was solely based off staff interviews. The Administrator stated she was the Abuse Coordinator for the facility and there was no discussion that Resident #39's fracture could have possibly been identified as an injury of unknown origin. The Administrator stated she was aware serious physical harm was reportable within 2 hours based on regulatory agencies and she was able to make the determination within 2 hours the cause of the injury from staff interviews. The Administrator confirmed the facility did not follow their policies for identifying, investigating, and reporting injuries of unknown origin. Resident #91 was admitted to the facility's secure unit on 1/4/2024, with diagnoses including Dementia with Agitation, and a history of wandering. Review of the medical record showed Resident #91 had severe cognitive impairment, and the resident's care plan did not capture the history of wandering behaviors, and no interventions were in place to protect the resident. Resident #40 was admitted to the facility's secure unit on 2/13/2024, with diagnoses including Dementia with Aggressive Behaviors and had a history of altercations with other residents and staff. Review of the medical record showed Resident #40 had severe cognitive impairment, and the resident's care plan did not capture the history of resident to resident altercations, aggressive behaviors, and had no interventions in place to protect other residents. Review of the facility's incident report dated 3/30/2024, showed Resident #91, wandered into Resident #40's room. Resident #40 became agitated and aggressive towards Resident #91, Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse (LPN) #2 separated the two residents. The resident to resident altercation between Residents #91 and #40, resulted in Resident #91 sustaining injuries of 3 scratches to the left cheek and 1 to the left eyebrow that required first aide; which had resolved by 4/11/2024. The report further showed the DON was made aware of the altercation between Residents #91 and #40 on 3/30/2024. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/2/2024, Registered Nurse (RN) #1 (the secure unit supervisor) stated Resident #91 wanders about the unit. Resident #91 wanders into other resident's rooms and handles their personal belongings, and this makes the other residents angry. Staff try to redirect the resident, but it was hard to keep her busy. RN #1 stated there was an incident report in her office about an altercation on 3/30/2024 between Resident #40 and Resident #91. RN #1 stated she was unaware of Resident #91 having injuries, then stated Resident #91 .might have some scratches on her face . RN #1 was unable to give any details about the altercation between Residents #91 and #40 that occurred on 3/30/2024. During continued interview, RN #1 stated the incident report regarding the altercation should have been discussed in the morning meeting on 4/1/2024, but the meeting was cancelled due to the appearance of the state surveyors. RN #1 was unaware when the incident report would be discussed. During an interview on 4/5/2024 at 4:19 PM, the DON confirmed the incident had not been thoroughly investigated and had not reported to appropriate local and state designated authorities or identified as abuse due to the resident's low Brief Interview for Mental Status (BIMS) score of 3 for Resident #91 and 4 for Resident #40. The DON confirmed the facility failed to follow their abuse policy. Resident #24 was admitted to the facility on [DATE], with diagnoses including Alzheimer's and Dementia; and had severe cognitive impairment. Resident #73 was admitted to the facility on [DATE], with diagnoses including Dementia and unspecified symptoms and signs involving cognitive functions and awareness; and had severe cognitive impairment. Review of a Significant Event Call (SEC) worksheet dated 2/9/2024, showed the resident-to-resident altercation between Residents #24 and #73 was discussed with the Administrator, DON, Director of Resident Advocate Program, [NAME] President (VP) of Operations, VP of Regulatory Compliance and QAPI Program Consultant, Chief Regulatory and Compliance Officer, and the VP of Clinical Services. It was determined on the SEC call that the root cause analysis of the altercation was the resident's diagnoses of dementia and severe cognitive impairment and was not a reportable altercation to the designated authorities. During an interview on 4/5/2024 at 12:20 PM, the Administrator stated she was the facility's Abuse Coordinator. The Administrator stated the facility determined if a resident's actions were willful or not based off their cognition status. During a telephone interview on 4/5/2024 at 7:32 PM, RN #5 stated she observed Residents #24 and #73, in a physical altercation. Both residents were .open hand slapping each other . Resident #24 was .getting in . Resident #73's closet and trying to take clothes from Resident #73's closet. Resident #24 was removed from the room to de-escalate the situation. Resident #73 told RN #5 .he's in my stuff .get him out of my room . and Resident #24 stated .this is my stuff . Resident #24 sustained a small bruise to the bridge of his nose, a small abrasion on the top of his head, and scattered redness that faded within a few hours on his face. Resident #73 sustained a small bruise on the bridge of his nose. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2024 at 10:58 AM, the DON stated RN #5 notified her via telephone that Resident #24 had gotten into Resident #73's closet and Resident #73 hit Resident #24 on top of the head. The DON confirmed both residents were injured because of the altercation. Resident #24 had an abrasion on his head, redness to his face, and a bruise on his nose. Resident #73 had a small bruise on the bridge of his nose. The DON notified the Administrator immediately and an SEC call was conducted with .corporate . on 2/9/2024 at 8:30 PM, to discuss the incident and determine if it was a reportable incident. The altercation was discussed during the SEC call, and it was determined it did not meet the definition of abuse due to the residents' cognition. Both residents had poor cognition with low BIMS scores and could not have acted willfully. The facility's Abuse Prohibition/Investigative Policy was reviewed with the DON who confirmed the residents hitting each other over Resident #24 getting in Resident #73's closet was willful and deliberate with resulting physically injuries and should have been considered abuse. The DON confirmed the facility's abuse policy was not followed for the resident-to-resident altercation between Residents #24 and #73. During an interview, review of facility documentation, and review of the facility's abuse policies on 4/6/2023 at 12:33 PM, the Administrator stated she .vaguely . recalled the resident-to-resident altercation between Residents #24 and #73. RN #5 witnessed an altercation between the residents on 2/9/2023.From my recollection ., the residents were roommates and had a physical altercation about one being in the other's closet and they were separated . The Administrator was made aware of the altercation by the DON but was unable to recall the date or time. The DON went to the facility and interviewed staff regarding the incident and the Administrator reviewed both residents' medical records. The DON and Administrator discussed their findings after the incident and .we determined that the residents had conflicting personalities and were not a good fit for each other .Staff de-escalated the situation and separated them . The Administrator confirmed Resident #24 sustained a small abrasion to the top of the scalp, redness on the face, and a bruise to the bridge of the nose and Resident #73 sustained a bruise to the bridge of his nose where his glasses rested. The Administrator confirmed both residents sustained injuries from the altercation. The Administrator stated the BIMS score was reviewed to determine if the residents acted willfully. Resident #73 had a BIMS of 4 and Resident #24 had a BIMS of 3. The Administrator stated there was an SEC call via teams to discuss the altercation with members of the governing body present. During the call, it was determined that the root cause was the residents' .dementia, cognition status, and conflicting personalities . The Administrator confirmed the incident was not identified as abuse because of the residents' cognition status. The Administrator stated .we identified it as a behavior and not abuse . The facility's Abuse Prohibition/Investigative Policy and the Abuse, Neglect, Exploitation and Misappropriation Prevention Program policies were reviewed with the Administrator who confirmed the facility did not follow its abuse policies. Resident #46 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. Resident #44 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #44's Progress Note, dated 2/12/2024 at 8:44 AM, showed NP #1 followed up with Resident #44 after an altercation with another resident. It was noted .Chief Complaint/Nature of Presenting Problem: Follow up on encounter with another resident .Last night she was sitting there speaking with another resident when a confused resident came and attempted to get into her room. According to [Resident #44's first name] they had a verbal exchange and he attempted to hit her, and in the exchange, she accidently scratched him with her fingernail. She denies injury and the other resident has been moved to another hall. She tells me he accused her of attacking him however she was just attempting to defend herself . Review of Resident #46's Progress Notes dated 2/12/2024 at 8:58 AM, showed NP #1 saw the resident after a resident-to-resident altercation. It was noted .Chief Complaint/Nature of Presenting Problem: Abrasion left eye and right forearm .advanced dementia and psychosis .He often has delusions of seeing his dead wife and sometimes searches forher [for her]. Last p.m. he was coming down the hallway and attempting to go into another resident's room .When the other resident who also has dementia attempted to stop him there was an exchange between the 2 and he got scratched by her fingernails. He has a very small abrasion underneath his left eye and a larger abrasion on his right inner forearm. He has been moved to another unit and this morning he is lying in bed and calm. He does remember the exchange and tells me that woman tried to stop me from going in that room he does not seem to understand that the room he was entering was not a common area .Physical Exam .Skin .Approximate 1 cm [centimeter] abrasion below the left eye there is no bleeding .Approximate 4 cm x 2 cm abrasion on right forearm appears somewhat superficial . Review of Resident's #46 and #44 medical record showed no additional documentation of the resident-to-resident altercation between the two residents. During an interview on 4/8/2024 at 10:19 AM, the DON stated she was made aware of the altercation between Residents #44 and #46 the next morning as the nurse was leaving her shift, but it was not considered abuse due to the cognition level of each resident. During an interview on 4/9/2024 at 12:10 PM, with the DON and the Administrator, the Administrator stated for an allegation to be valid or considered abuse, .the resident has to understand what they are doing . The DON stated, .that would be a BIMS of 13 or 14 at least . If a resident had major mental illness and a BIMS of 15, it would be up to the staff member to judge if a resident was competent to make an allegation. When asked if every employee whose task is reporting was competent to make the judgement if a resident can make an allegation with validity, the DON confirmed not all staff are trained or capable of making that judgement before reporting an incident. The DON stated there was no documentation of an incident report or investigation for a resident to resident altercation between Resident #46 and Resident #44. Continues interviews with the DON and Administrator confirmed the resident to resident altercation between Residents #46 and #44 was not recognized as abuse due to their low cognition, Resident #44 did not act willfully, the altercation was not documented, thoroughly invested to determine a root cause analysis, and was not reported to the local and state designated authorities. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/5/2024 at 12:20 PM, the Administrator stated .I am the Abuse Coordinator .; resident to resident altercations are discussed on SEC calls with the Governing Body to determine if the incidents are reportable. The Administrator stated Residents #24, #73 were discussed in SEC calls with the Governing Body. She also stated Resident #39's fracture had been discussed on an SEC call after she and the DON had been made aware of the fracture, but she had misplaced the meeting minutes and was unable to produce the SEC worksheet for Resident #39. During an interview on 4/6/2024 at 12:33 PM, the Administrator stated, .we identified it [resident to resident altercations] as a behavior .not abuse . The facility had not identified concerns related to abuse investigations, reporting, and care planning processes only after the start of the regulatory surveying process. The Administrator stated, .resident to resident altercations are reviewed according to the 'Unusual Occurrence Policy' . SEC call are performed with the members of the governing body to determine if the altercations was a reportable event. The governing body on the SEC calls make the determination if an event is reportable. Further interview revealed the Administrator stated, .it was determined the root cause was the residents' dementia .cognition status . Continued interview showed the Administrator was unable to produce incident reports or thorough investigations to determine the root cause analysis were completed for Residents #91, #40, #24, #73, #46, #44, and #39. The Administrator stated there had been one QAA (Quality Assessment and Assurance) meeting held on 1/31/2024 and was unable to provide any QAA sign in sheets or meeting minutes prior to that meeting. During an interview on 4/8/2024 at 12:20 PM, the VP of Regulatory Compliance and QAPI Program Consultant stated the Governing Body is ultimately responsible for the oversight of the facility day to day operations, Administration and the QAPI program. One member of the Governing Body is part of the QAPI committee. If a concern is identified, then a Process Improvement Plan (PIP) will be developed to correct the concern, if the PIP is not working, then it is recommended to expand the PIP until there is an acceptable resolution. The VP of Regulatory Compliance and QAPI Program Consultant stated unusual events are discussed through SEC calls to include the VP of Operations and VP of Clinical Services. The Administrator and the DON complete a SEC worksheet and investigation of incidents, then they upload the information to the facility's computer system prior to the call. During the call the Administrator and the DON are asked if the incidents discussed are reportable events, then the SEC members on the call will state if they agree or disagree with the decision made by the Administrator and the DON. There had been no identified concerns related to abuse prior to the survey process. The VP of Regulatory Compliance and QAPI Program Consultant stated it was expectation that all allegations of abuse be thoroughly investigated, to include witness statements, residents involved (if possible), all staff on the unit, assessment of the residents involved along with other residents on the unit or facility, and assessment and input from the provider. The VP of Regulatory Compliance and QAPI Program Consultant confirmed the facility failed to recognize allegations of resident to resident altercations and an injury of unknown origin as abuse. The facility failed to thoroughly investigate to determine a root cause analysis and report the incidents to the local and state designated authorities. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/8/2024 at 4:20 PM, the Administrator stated QAPI meets monthly with the required members in attendance. The QAPI committee is made aware of issues through daily stand-up meetings, clinical record reviews, and 24 hour reports from the Clinical Dashboard. Each department brings concerns to QAPI. The information provided in QAPI was reported to the Governing Body for oversight. The Administrator confirmed she is ultimately responsible for reviewing incident reports to ensure they are completed, and thorough investigations are being done. The Administrator confirmed incident reports are not being reviewed as they should be. When asked if the facility had an effective QAPI program, the Administrator stated, .yes .We have room for improvement .no program is perfect .but I believe our QAPI process is effective . The Administrator confirmed the facility had not followed their policies for identifying, investigating, and reporting all allegations of abuse. The Administrator continued to state she felt like the facility had an effective QAPI program. Refer to F600, F609, F610, F656, F837, and F867. Validation of the Removal Plan to remove the immediate Jeopardy (IJ) was conducted on 4/11/2024 through review of facility documentation, medical record reviews, and interviews. The surveyors verified onsite on 4/11/2024, the Administrator and DON received education provided by the VP of Regulatory Compliance & QAPI Program Consultant how to identify, investigate, and report future allegations of abuse and injury of unknown origin. The education included review of the Administrator and DON's responsibility to operate/manage the facility efficiently and effectively to ensure each resident maintains the highest practicable physical, mental, and psychosocial well-being. A review of the tools to be used for future allegations and interviews with the Administrator and DON confirmed they acknowledged their roles and responsibilities. The surveyors verified onsite on 4/11/2024, the Administrator and DON confirmed staff will receive education on how to identify abuse. Staff education will be conducted by the Risk Manager and the DON. The DON will be responsible for monitoring compliance. The surveyors verified onsite on 4/11/2024, the Director of Reimbursement and Clinical Services will provide daily oversight of the facility for the next 2 weeks. After two weeks, the Governing Body, facility leadership and members of the operations, compliance and QAPI corporate staff will determine if additional oversight is needed. The surveyors verified onsite on 4/11/2024, the Administrator and the DON confirmed Ad-Hoc (meeting for a particular purpose) QAPI meetings will be held weekly with representatives of the Governing Body, members of the operation, compliance and QAPI corporate staff to review results of audits, rounds, patterns/trends identified through SOC (risk) meetings, and other compliance monitoring activities. The surveyors verified onsite on 4/11/2024, the facility will continue to hold SEC calls to review and discuss events and incidents. The surveyors verified onsite on 4/11/2024, QAPI meetings will be attended by the QAPI team and members of the Governing Body. Based on patterns/trends identified, an educational plan will be created for the facility.

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, job description review, facility documentation review, medical record review, observation, and interview, the facility's Governing Body failed to provide effective leadership and oversight of the facility's Administration to ensure residents had the right to be free from abuse, failed to identify resident to resident altercations or injuries of unknown origin as the potential for abuse, failed to investigate resident to resident altercations and an injury of unknown origin, and failed to report resident to resident altercations and injury of unknown origin to the local and state designated authorities as required for 4 residents (Residents #39, #91,#24, and #46) of 37 residents reviewed for injury of unknown origin and abuse. The Governing Body's failure to provide adequate leadership and to oversee and maintain an effective QAPI program resulted in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The Governing Body's failure to maintain effective leadership and oversight of the facility had the potential or likelihood to impact all 101 residents of the facility. The Administrator, Director of Nursing, [NAME] President (VP) of Regulatory Compliance and QAPI Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-837 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited Immediate Jeopardy at F-837 at a scope and severity of K. The IJ began on 12/21/2023 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/10/2024 for F-837. Noncompliance continues at F-837 at a scope and severity of E. The corrective actions were validated on site by the surveyors on 4/11/2024 for F-837. The facility is required to submit a Plan of Correction (POC). The findings include: (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Injury of Unknown Source, showed .This policy will provide guidelines related to unexplainable injuries .Any observed unexplained injuries shall be reported to the resident's nurse .The attending physician/Nurse practitioner notification will be completed .if the injury is of unknown source, reporting .procedures shall be implemented in accordance with the facility's abuse policy and procedures .An injury should be classified as an 'injury of unknown source' when .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of .the extent of the injury . Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised on 4/2014, showed .This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems .objectives of the QAPI Plan .Provide a means to identify and resolve present and potential negative outcomes related to resident care .Reinforce and build upon effective systems and processes related to the delivery of quality care .Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome .Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program .Authority .The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program .The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, showed .Residents have the right to be free from abuse .This includes .physical abuse . Protect residents from abuse .by anyone including .other residents .Establish .maintain a culture of compassion .caring for all residents .particularly those with behavioral, cognitive or emotional problems . Provide staff .training .that include .identification .reporting of abuse .handling .physically aggressive resident behavior .Implement measures to address factors that may lead to abusive situations .Identify .investigate all possible incidents of abuse .report any allegations within timeframes required by federal requirements. Protect residents from any further harm .QAPI review and analysis of reports, allegations .findings of abuse . Review of the facility's police titled, Governing Body, dated 2/2023, showed .The facility will have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility .governing body is responsible and accountable for the QAPI program .The governing body will have a process in place by which the administrator .Reports to the governing body .What specific types of problems and information (i.e. [example] .allegations of abuse or neglect .) .How the administrator is held accountable and reports information about the facility's management and operation . Review of the Administrator's Job Description signed and dated by the Administrator on 10/13/2023, showed . The duties and responsibilities of the Administrator include supervising all aspects of facility operation in accordance with current federal, state, local standards, guidelines, and regulations governing the facility and as directed by the Board of Directors . (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's assessment dated [DATE], showed the facility admission process and continuing care decisions were reviewed by Administration. Any staff education needed prior to the resident's admission or identified after admission was to be conducted by Nursing Administration. The facility identified the need to provide services and general care based on the resident's needs which included mobility and fall/fall with injury prevention, mental health and behavior management, and provide person-centered care. Staff training, education, and competencies included Abuse training that addressed care management for persons with dementia and resident abuse prevention. Resident #39 was admitted to the facility on [DATE] with diagnoses including Abnormal Mobility, Maltreatment, with severe cognitive impairment, and bilateral lower extremities contractures. On 12/20/2023, an unknown CNA reported to LPN #6, Resident #39 was found to have right hip swelling with pain, the resident was sent to the emergency room (ER) for evaluation and treatment. On 12/21/2023, the facility was notified by the hospital, Resident #39 had a left femur fracture. The DON conducted staff interviews; it was discovered Resident #39 had a witnessed assisted fall on 12/11/2023 (9 days prior) with no complaints of pain after the assisted fall. The DON stated she was unable to interview Resident #39 until 12/26/2023; after the resident returned from the hospital (6 days after the fracture was identified). The incident was not identified as an injury of unknown origin; the DON stated .I didn't think about it like that . Interview with the DON and Administrator confirmed an incident report and thorough investigation was not completed to determine a root cause analysis for Resident #39's injury of unknown origin and was not reported to the local and state designated authorities. Resident #91 was admitted to the facility's secure unit on 1/4/2024, with diagnoses including Dementia with Agitation, and a history of wandering. Resident #40 was admitted to the facility's secure unit on 2/13/2024, with diagnoses including Dementia with Aggressive Behaviors and had a history of altercations with other residents and staff. On 3/30/2024, Resident #91, with severe cognitive impairment, wandered into Resident #40's room. Resident #40, with severe cognitive impairment, became agitated and aggressive towards Resident #91, Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse (LPN) # 2 separated the two residents. The resident to resident altercation between Residents #91 and #40, resulted in Resident #91 sustaining injuries of 3 scratches to the left cheek and 1 to the left eyebrow that required first aide; which had resolved by 4/11/2024. Resident #91's care plan did not capture the history of wandering behaviors, and no interventions were in place to protect the resident. Resident #40's care plan did not capture the history of resident to resident altercations, aggressive behaviors, and had no interventions in place to protect other residents. The resident to resident altercation was not discussed in the morning stand up meeting in the facility on 4/1/2024. Interview with the DON showed the incident had not been thoroughly investigated and had not been reported to appropriate local and state designated authorities or identified as abuse due to the resident's low Brief Interview for Mental Status (BIMS) score of 3 for Resident #91 and 4 for Resident #40. The facility failed to follow their abuse policy. (continued on next page)

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	445292	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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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 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #24 was admitted to the facility on [DATE], with diagnoses including Alzheimer's and Dementia; and had severe cognitive impairment. Resident #73 was admitted to the facility on [DATE], with diagnoses including Dementia and had severe cognitive impairment. On 2/9/2024, Residents #24 and #73, were observed by Registered Nurse (RN) #5, in a physical altercation. both residents were .open hand slapping each other . Resident #24 was .getting in . and trying to take clothes from Resident #73's closet. Resident #24 was removed from the room to de-escalate the situation. Resident #73 told RN #5 .he's in my stuff .get him out of my room . and Resident #24 stated .this is my stuff . Resident #24 sustained a small bruise to the bridge of his nose, a small abrasion on the top of his head, and scattered redness that faded within a few hours on his face. Resident #73 sustained a small bruise on the bridge of his nose. The resident-to-resident altercation was discussed on a Significant Event Call (SEC) with the Administrator, DON, Director of Resident Advocate Program, [NAME] President (VP) of Operations, VP of Regulatory Compliance and QAPI Program Consultant, Chief Regulatory and Compliance Officer, and the VP of Clinical Services. It was noted on the SEC call that the root cause analysis of the altercation was the resident's dementia/cognition and was determined not to be a reportable altercation. Interviews with the DON and Administrator revealed the resident-to-resident altercation was not abuse because the residents' cognition was poor, so their actions were not willful. The resident-to-resident altercation was not thoroughly investigated, reported to the local and state designated authorities, or identified as abuse due to the resident's low BIMS score of 3 for Resident #24 and 4 for Resident #73. Resident #46 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. Resident #44 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. Review of a Nurse Practitioner's note showed on 2/11/2024, Resident #46 tried to enter Resident #44's room, Resident #44 scratched Resident #46s right forearm and left side of the face. The DON stated there was no documentation of an incident report or investigation for a resident to resident altercation between Resident #46 and Resident #44. Interviews with the DON and Administrator confirmed the resident to resident altercation between Residents #46 and #44 was not recognized as abuse due to their low cognition, Resident #44 did not act willfully, the altercation was not documented, thoroughly investigated to determine a root cause analysis, or reported to the local and state designated authorities. During an interview on 4/5/2024 at 10:55 AM, the Administrator stated there had been no discussions with nursing, administration, or the governing body about Resident #39's fracture possibly being identified as an injury of unknown origin due to the time lapse from the date the resident was lowered to the floor by staff (12/11/2023); to the date Resident #39 experienced lower extremity pain and swelling, and was sent to the ED (12/20/2023);to when the leg fracture was identified and the facility was notified by the hospital (12/21/2023). When asked if a root cause analysis was performed for Resident #39's injury of unknown origin, the Administrator stated she could not produce one. During an interview on 4/5/2024 at 12:20 PM, the Administrator stated .I am the Abuse Coordinator .; resident to resident altercations are discussed on SEC calls with the Governing Body to determine if the incidents are reportable. The Administrator stated Residents #24, #73 were discussed in SEC calls with the Governing Body. She also stated Resident #39's fracture had been discussed on an SEC call after she and the DON had been made aware of the fracture, but she had misplaced the meeting minutes and was unable to produce the SEC worksheet for Resident #39. (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/6/2024 at 12:33 PM, the Administrator stated, .we identified it [resident to resident altercations] as a behavior .not abuse . The facility had not identified concerns related to abuse investigations, reporting, and care planning processes only after the start of the regulatory surveying process. The Administrator stated, .resident to resident altercations are reviewed according to the 'Unusual Occurrence Policy' . SEC call are performed with the members of the governing body to determine if the altercations was a reportable event. The governing body on the SEC calls make the determination if an event is reportable. Further interview revealed the Administrator stated, .it was determined the root cause was the residents' dementia .cognition status . Continued interview showed the Administrator was unable to produce incident reports or thorough investigations to determine the root cause analysis were completed for Residents #91, #40, #24, #73, #46, #44, and #39. The Administrator stated there had been one QAA (Quality Assessment and Assurance) meeting held on 1/31/2024 and was unable to provide any QAA sign in sheets or meeting minutes prior to that meeting. During an interview on 4/8/2024 at 12:20 PM, the VP of Regulatory Compliance and QAPI Program Consultant stated the Governing Body was ultimately responsible for the oversight of the facility's day to day operations, Administration and the QAPI program, and one member of the Governing Body was part of the QAPI committee. The VP of Regulatory Compliance and QAPI Program Consultant stated if a concern was identified, then a Process Improvement Plan (PIP) was developed to correct the concern, if the PIP was not working, then it was recommended to expand the PIP until there was an acceptable resolution. The VP of Regulatory Compliance and QAPI Program Consultant stated unusual events were discussed through SEC calls to include the VP of Operations and VP of Clinical Services. The Administrator and the DON completed a SEC worksheet and conducted investigations of the incidents and uploaded the information to the facility's computer system prior to the call for discussion. During the call the Administrator and the DON were asked if the incidents discussed were thought to be reportable events, then the SEC members on the call stated if they agreed or disagreed with the decision made by the Administrator and the DON. There had been no identified concerns related to abuse or allegations of abuse prior to the State Agency survey process. The VP of Regulatory Compliance and QAPI Program Consultant stated it was the expectation that all allegations of abuse be thoroughly investigated, to include witness statements, any residents involved (if possible), all staff on the unit, assessments of the residents involved along with other residents on the unit or facility, and an assessment and input from the provider. The VP of Regulatory Compliance and QAPI Program Consultant confirmed the facility failed to recognize allegations of resident to resident altercations and an injury of unknown origin as abuse. The facility failed to thoroughly investigate to determine a root cause analysis and report the incidents to the local and state designated authorities. The VP of Regulatory Compliance and QAPI Program Consultant stated the facility's QAPI program .had weaknesses .and was not effective . (continued on next page)

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F 0837 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/8/2024 at 4:20 PM, the Administrator stated QAPI meets monthly with the required members in attendance. The QAPI committee is made aware of issues through daily stand-up meetings, clinical record reviews, and 24 hour reports from the Clinical Dashboard. Each department brings concerns to QAPI. The information provided in QAPI was reported to the Governing Body for oversight. The Administrator confirmed she is ultimately responsible for reviewing incident reports to ensure they are completed, and thorough investigations are being done. The Administrator confirmed incident reports are not being reviewed as they should be. When asked if the facility had an effective QAPI program, the Administrator stated, .yes .We have room for improvement .no program is perfect .but I believe our QAPI process is effective . The Administrator confirmed the facility had not followed their policies for identifying, investigating, and reporting all allegations of abuse. The Administrator continued to state she felt like the facility had an effective QAPI program. During a review on 4/9/2024, of the QAPI meeting minutes date ranged 3/15/2023-3/28/2024, showed the meetings did not reflect the resident to resident altercations or injury of unknown origin had been discussed for Residents #39, #91, #40, #46, #44, and #39. Refer to F600, F609, F610, F656, F835, and F867. Validation of the Removal Plan to remove the Immediate Jeopardy (IJ) was conducted on 4/11/2024 through review of facility documentation, medical record reviews, and interviews. The surveyors verified onsite on 4/11/2024, the Administrator and DON received education provided by the VP of Regulatory Compliance & QAPI Program Consultant how to identify, investigate, and report future allegations of abuse and injuries of unknown origin. The education included review of the Administrator and DON's responsibility to operate/manage the facility efficiently and effectively to ensure each resident maintains the highest practicable physical, mental, and psychosocial well-being. A review of the tools to be used for future allegations and interviews with the Administrator and DON confirmed they acknowledged their roles and responsibilities. The surveyors verified onsite on 4/11/2024, the Administrator and DON confirmed staff will receive education on how to identify abuse. Staff education will be conducted by the Risk Manager and the DON. The DON will be responsible for monitoring compliance. The surveyors verified onsite on 4/11/2024, the Director of Reimbursement and Clinical Services will provide daily oversight of the facility for the next 2 weeks. After two weeks, the Governing Body, facility leadership and members of the operations, compliance and QAPI corporate staff will determine if additional oversight is needed. The surveyors verified onsite on 4/11/2024, The Administrator and the DON confirmed Ad-Hoc (meeting for a particular purpose) QAPI meetings will be held weekly with representatives of the Governing Body, members of the operation, compliance and QAPI corporate staff to review results of audits, rounds, patterns/trends identified through SOC (risk) meetings, and other compliance monitoring activities. The surveyors verified onsite on 4/11/2024, the facility will continue to hold SEC calls to review and discuss events and incidents. The surveyors verified onsite on 4/11/2024, QAPI meetings will be attended by the QAPI team and members of the Governing Body. Based on patterns/trends identified, an educational plan will be created for the facility.

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41782 Based on facility policy review, facility documentation review, medical record review, observation and interview, the facility's Quality Assurance Performance Improvement (QAPI) program failed to identify quality deficiencies, investigate, report, perform a root cause analysis to identify serious outcomes, develop and implement person centered interventions for 4 of 37 residents (Residents #39, #91, #24, and #46) related to an injury of unknown origin and abuse. The facility's failure to have an effective QAPI program resulted in an Immediate Jeopardy (IJ), (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The facility's failure to maintain an effective QAPI program and to identify serious outcomes and develop and implement person centered interventions related to abuse had the potential or likelihood to impact all 101 residents of the facility. The Administrator, Director of Nursing, [NAME] President (VP) of Regulatory Compliance and QAPI Consultant, Chief Operating Officer, Director of Reimbursement Services, and VP of Life Safety and Environmental Compliance were notified of the IJ for F-867 on 4/9/2024 at 7:05 PM in the facility's front office. The facility was cited Immediate Jeopardy at F-867 at a scope and severity of K. The facility was previously cited F-600 at a scope and severity of D for resident to resident abuse on a complaint survey on 6/28/2022 and 10/3/2023. The IJ began on 12/21/2023 and continued through 4/9/2024. The IJ ended on 4/10/2024 and was removed on site. An acceptable Removal Plan which removed the immediacy was provided by the facility on 4/10/2024 for F-867. Noncompliance continues at F-867 at a scope and severity of E. The corrective actions were validated on site by the surveyors on 4/11/2024 for F-867. The facility is required to submit a Plan of Correction (POC). The findings include: (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's undated policy titled, Injury of Unknown Source, showed .This policy will provide guidelines related to unexplainable injuries .Any observed unexplained injuries shall be reported to the resident's nurse .The attending physician/Nurse practitioner notification will be completed .if the injury is of unknown source, reporting .procedures shall be implemented in accordance with the facility's abuse policy and procedures .An injury should be classified as an 'injury of unknown source' when .The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and .The injury is suspicious because of .the extent of the injury . Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Plan, revised on 4/2014, showed .This facility shall develop, implement, and maintain an ongoing, facility-wide QAPI Plan designed to monitor and evaluate the quality and safety of resident care, pursue methods to improve care quality, and resolve identified problems .objectives of the QAPI Plan .Provide a means to identify and resolve present and potential negative outcomes related to resident care .Reinforce and build upon effective systems and processes related to the delivery of quality care .Establish and implement plans to correct deficiencies, and to monitor the effects of these action plans on resident outcome .Establish systems and processes to maintain documentation relative to the QAPI Program, as a basis for demonstrating that there is an effective ongoing program .Authority .The owner and/or governing board (body) of our facility shall be ultimately responsible for the QAPI Program .The Administrator is responsible for assuring that this facility's QAPI Program complies with federal, state, and local regulatory agency requirements .Implementation .The QAPI Committee shall oversee implementation of our QAPI Plan .This committee shall meet monthly to review reports, evaluate the significance of data, and monitor quality-related activities of all departments .The QAPI Committee shall oversee and authorize QAPI activities, including data-collection tools, monitoring tools, and the basis for and appropriateness and effectiveness of QAPI activities .Evaluation .The facility shall evaluate the effectiveness of its QAPI Program at least annually . Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated 4/2021, showed .Residents have the right to be free from abuse .This includes .physical abuse . Protect residents from abuse .by anyone including .other residents .Establish .maintain a culture of compassion .caring for all residents .particularly those with behavioral, cognitive or emotional problems . Provide staff .training .that include .identification .reporting of abuse .handling .physically aggressive resident behavior .Implement measures to address factors that may lead to abusive situations .Identify .investigate all possible incidents of abuse .report any allegations within timeframes required by federal requirements. Protect residents from any further harm .QAPI review and analysis of reports, allegations .findings of abuse . Review of the facility's assessment dated [DATE], showed the facility admission process and continuing care decisions were reviewed by Administration. Any staff education needed prior to the resident's admission or identified after admission was conducted by Nursing Administration. The facility identified the need to provide services and general care based on resident's needs which included mobility and fall/fall with injury prevention, mental health and behavior management, and provide person-centered care. Staff training, education, and competencies included Abuse training that addressed care management for persons with dementia and resident abuse prevention. (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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #39 was admitted to the facility on [DATE] with diagnoses including Abnormal Mobility, Maltreatment, with severe cognitive impairment, and bilateral lower extremities contractures. On 12/20/2023, an unknown CNA reported to LPN #6 Resident #39 was found to have right hip swelling with pain, the resident was sent to the emergency room (ER) for evaluation and treatment. On 12/21/2023, the facility was notified by the hospital, Resident #39 had a left femur fracture. The DON conducted staff interviews; it was discovered Resident #39 had a witnessed assisted fall on 12/11/2023 (9 days prior) with no complaints of pain after the assisted fall. The DON stated she was unable to interview Resident #39 until 12/26/2023; after the resident returned from the hospital (6 days after the fracture was identified). The incident was not identified as an injury of unknown origin; the DON stated .I didn't think about it like that . Interview with the DON and Administrator confirmed an incident report and thorough investigation was not completed to determine a root cause analysis for Resident #39's injury of unknown origin and was not reported to the local and state designated authorities. Resident #91 was admitted to the facility's secure unit on 1/4/2024, with diagnoses including Dementia with Agitation, and a history of wandering. Resident #40 was admitted to the facility's secure unit on 2/13/2024, with diagnoses including Dementia with Aggressive Behaviors and had a history of altercations with other residents and staff. On 3/30/2024, Resident #91, with severe cognitive impairment, wandered into Resident #40's room. Resident #40, with severe cognitive impairment, became agitated and aggressive towards Resident #91, Certified Nursing Assistant (CNA) #1 and Licensed Practical Nurse (LPN) # 2 separated the two residents. The resident to resident altercation between Residents #91 and #40, resulted in Resident #91 sustaining injuries of 3 scratches to the left cheek and 1 to the left eyebrow that required first aide; which had resolved by 4/11/2024. Resident #91's care plan did not capture the history of wandering behaviors, and no interventions were in place to protect the resident. Resident #40's care plan did not capture the history of resident to resident altercations, aggressive behaviors, and had no interventions in place to protect other residents. The resident to resident altercation was not discussed in morning stand up meeting in the facility on 4/1/2024. Interview with the DON showed the incident was not thoroughly investigated and allegations of abuse had not been reported to appropriate local and state designated authorities, or identified as abuse, due to the resident's low Brief Interview for Mental Status (BIMS) score of 3 for Resident #91 and 4 for Resident #40. The facility failed to follow their abuse policy. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #24 was admitted to the facility on [DATE], with diagnoses including Alzheimer's and Dementia; and had severe cognitive impairment. Resident #73 was admitted to the facility on [DATE], with diagnoses including Dementia and had severe cognitive impairment. On 2/9/2024, Residents #24 and #73, were observed by Registered Nurse (RN) #5, in a physical altercation. Both residents were .open hand slapping each other . Resident #24 was .getting in . and trying to take clothes from Resident #73's closet. Resident #24 was removed from the room to de-escalate the situation. Resident #73 told RN #5 .he's in my stuff .get him out of my room . and Resident #24 stated .this is my stuff . Resident #24 sustained a small bruise to the bridge of his nose, a small abrasion on the top of his head, and scattered redness on his face that faded within a few hours. Resident #73 sustained a small bruise on the bridge of his nose. The resident-to-resident altercation was discussed on a Significant Event Call (SEC) with the Administrator, DON, Director of Resident Advocate Program, [NAME] President (VP) of Operations, VP of Regulatory Compliance and QAPI Program Consultant, Chief Regulatory and Compliance Officer, and the VP of Clinical Services. It was determined on the SEC call that the root cause of the altercation was the resident's dementia/cognition and was not a reportable altercation. Interviews with the DON and Administrator revealed the resident-to-resident altercation was not abuse because the residents' cognition was poor, so their actions were not willful. The resident-to-resident altercation was not thoroughly investigated, reported to the local and state designated authorities, or identified as abuse due to the resident's low BIMS score of 3 for Resident #24 and 4 for Resident #73. Resident #46 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. Resident #44 was admitted to the facility on [DATE] with diagnoses including Dementia and Anxiety; and had moderate cognitive impairment. Review of a Nurse Practitioner's note showed on 2/11/2024, Resident #46 tried to enter Resident #44's room, Resident #44 scratched Resident #46s right forearm and left side of the face. The DON stated there was no documentation of an incident report or investigation for a resident to resident altercation between Resident #46 and Resident #44. Interviews with the DON and Administrator confirmed the resident to resident altercation between Residents #46 and #44 was not recognized as abuse due to their low cognition, Resident #44 did not act willfully, the altercation was not documented, or thoroughly investigated to determine a root cause analysis, and was not reported to the local and state designated authorities. During an interview on 4/5/2024 at 10:55 AM, the Administrator stated there had been no discussions with nursing, administration, or the governing body about Resident #39's fracture possibly being identified as an injury of unknown origin due to the time lapse from the date the resident was lowered to the floor by staff (12/11/2023); to the date Resident #39 experienced lower extremity pain and swelling, and was sent to the ED (12/20/2023);to when the leg fracture was identified and the facility was notified by the hospital (12/21/2023). When asked if a root cause analysis was performed for Resident #39's injury of unknown origin, the Administrator stated she could not produce one. During an interview on 4/5/2024 at 12:20 PM, the Administrator stated .I am the Abuse Coordinator .; resident to resident altercations are discussed on SEC calls with the Governing Body to determine if the incidents are reportable. The Administrator stated Residents #24, #73 were discussed in SEC calls with the Governing Body. She also stated Resident #39's fracture had been discussed on an SEC call after she and the DON had been made aware of the fracture, but she had misplaced the meeting minutes and was unable to produce the SEC worksheet for Resident #39. (continued on next page)

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F 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 4/6/2024 at 12:33 PM, the Administrator stated, .we identified it [resident to resident altercations] as a behavior .not abuse . The facility had not identified concerns related to abuse investigations, reporting, and care planning processes only after the start of the regulatory surveying process. The Administrator stated, .resident to resident altercations are reviewed according to the 'Unusual Occurrence Policy' . SEC call are performed with the members of the governing body to determine if the altercations was a reportable event. The governing body on the SEC calls make the determination if an event is reportable. Further interview revealed the Administrator stated, .it was determined the root cause was the residents' dementia .cognition status . Continued interview showed the Administrator was unable to produce incident reports or thorough investigations to determine the root cause analysis were completed for Residents #91, #40, #24, #73, #46, #44, and #39. The Administrator stated there had been one QAA (Quality Assessment and Assurance) meeting held on 1/31/2024 and was unable to provide any QAA sign in sheets or meeting minutes prior to that meeting. During an interview on 4/8/2024 at 12:20 PM, the VP of Regulatory Compliance and QAPI Program Consultant stated the Governing Body is ultimately responsible for the oversight of the facility day to day operations and QAPI program. One member of the Governing Body was part of the QAPI committee and if a concern was identified, a Process Improvement Plan (PIP) was developed to correct the concern, if the PIP was not working, then it was recommended to expand the PIP until there was an acceptable resolution. There had been no identified concerns related to abuse or abuse allegations prior to the State Agency's survey process. The VP of Regulatory Compliance and QAPI Program Consultant confirmed the facility failed to recognize allegations of resident to resident altercations and an injury of unknown origin as abuse. The facility failed to thoroughly investigate to determine a root cause analysis and report the incidents to the local and state designated authorities. The VP of Regulatory Compliance and QAPI Program Consultant stated the facility's QAPI program .had weaknesses .and was not effective . During an interview on 4/8/2024 at 4:20 PM, the Administrator stated QAPI meets monthly with the required members in attendance. The QAPI committee is made aware of issues through daily stand-up meetings, clinical record reviews, and 24 hour reports from the Clinical Dashboard. Each department brings concerns to QAPI. The information provided in QAPI was reported to the Governing Body for oversight. The Administrator confirmed she is ultimately responsible for reviewing incident reports to ensure they are completed, and thorough investigations are being done. The Administrator confirmed incident reports are not being reviewed as they should be. When asked if the facility had an effective QAPI program, the Administrator stated, .yes .We have room for improvement .no program is perfect .but I believe our QAPI process is effective . The Administrator confirmed the facility had not followed their policies for identifying, investigating, and reporting all allegations of abuse. The Administrator continued to state she felt like the facility had an effective QAPI program. During a review on 4/9/2024, of the QAPI meeting minutes date ranged 3/15/2023-3/28/2024, showed the meetings did not reflect the resident to resident altercations or injury of unknown origin had been discussed for Residents # 91, #40, #46, #44, and #39. Refer to F600, F609, F610, F656, F835, and F837 Validation of the Allegation of Compliance (AOC) Removal Plan to remove the immediacy of the Jeopardy (IJ) was conducted on 4/11/2024 through review of facility documentation, medical record reviews, and interviews. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445292	A. Building B. Wing	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beech Tree Health and Rehabilitation	240 Hospital Lane Jellico, TN 37762

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 0867 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The surveyors verified onsite on 4/11/2024, the Administrator and DON received education provided by the VP of Regulatory Compliance & QAPI Program Consultant how to identify, investigate, and report future allegations of abuse and injury of unknown origin. The education included review of the Administrator and DON's responsibility to operate/manage the facility efficiently and effectively to ensure each resident maintains the highest practicable physical, mental, and psychosocial well-being. A review of the tools to be used for future allegations and interviews with the Administrator and DON confirmed they acknowledged their roles and responsibilities. The surveyors verified onsite on 4/11/2024, the Administrator and DON confirmed staff will receive education on how to identify abuse. Staff education will be conducted by the Risk Manager and the DON. The DON will be responsible for monitoring compliance. The surveyors verified onsite on 4/11/2024, the Director of Reimbursement and Clinical Services will provide daily oversight of the facility for the next 2 weeks. After two weeks, the Governing Body, facility leadership and members of the operations, compliance and QAPI corporate staff will determine if additional oversight is needed. The surveyors verified onsite on 4/11/2024, The Administrator and the DON confirmed Ad-Hoc QAPI meetings will be held weekly with representatives of the Governing Body, members of the operation, compliance and QAPI corporate staff to review results of audits, rounds, patterns/trends identified through SOC (risk) meetings, and other compliance monitoring activities. The surveyors verified onsite on 4/11/2024, the facility will continue to hold SEC calls to review and discuss events and incidents. The surveyors verified onsite on 4/11/2024, QAPI meetings will be attended by the QAPI team and members of the Governing Body. Based on patterns/trends identified, an educational plan will be created for the facility.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41291 Based on facility policy review, medical record review, observations, and interviews, the facility failed to offer hand hygiene assistance to residents prior to meals for 5 residents (Residents #78, #203, #50, #54, and #79) observed in 1 of 2 dining areas and 2 of 3 resident units observed for meal tray distribution. The findings include: Review of the facility's policy titled, Hand Hygiene, dated 6/2023, showed .perform proper hand hygiene procedures to prevent the spread of infection .If residents need assistance with hand hygiene, staff should assist with washing hands .before meals . Resident #78 was admitted to the facility on [DATE] with diagnoses including Dementia, Mild Neurocognitive Disorder, and Major Depressive Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], showed Resident #79 was cognitively intact. During an observation on 4/1/2024 at 12:42 PM, Licensed Practical Nurse (LPN) #9 delivered the lunch meal to Resident #78. The LPN assisted the resident with tray set up. Resident #78 immediately started eating the lunch meal and LPN #9 exited the room without offering hand hygiene assistance to Resident #78. During an interview on 4/1/2024 at 12:43 PM, LPN #9 confirmed she had not offered hand hygiene assistance to the resident and stated .we are supposed to offer them hand sanitizer or a washcloth . for hand hygiene prior to meals. Resident #203 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Anxiety Disorder, and Dementia. Review of an admission MDS assessment dated [DATE], showed Resident #203 had severe cognitive impairment. During an observation on 4/1/2024 at 12:44 PM, Certified Nursing Assistant (CNA #9) delivered the lunch meal tray to Resident #203. The CNA assisted the resident to sit up in the bed, set up the resident's tray, and left the room without offering the resident hand hygiene assistance. During an interview on 4/1/2024 at 12:45 PM, CNA #9 confirmed she had not offered hand hygiene assistance to the resident and stated .I should have offered a wash cloth or to take him to the bathroom to wash his hands . Resident #50 was admitted to the facility on [DATE] with diagnoses including Generalized Arthritis and Alzheimer's Disease. (continued on next page)

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	445292	A. Building B. Wing	04/11/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a quarterly MDS assessment dated [DATE] showed Resident #50 had severe cognitive impairment. During an observation on 4/1/2024 at 12:21 PM, CNA #10 delivered a lunch tray into room [ROOM NUMBER]. The CNA did not offer Resident #50 assistance with hand hygiene or ask if he had washed his hands. During an interview on 4/1/2024 at 12:25 PM, CNA #10 confirmed she had not offered to provide Resident #50 with hand hygience assistance prior to serving the resident's food. Resident #54 was admitted to the facility on [DATE] with diagnoses including Pneumonia and Parkinson's Disease. Review of a quarterly MDS assessment dated [DATE], showed Resident #54 had severe cognitive impairment. During an observation on 4/1/2024 at 12:15 PM, on the 300 hall, CNA #12 was delivering a lunch tray in room [ROOM NUMBER] without offering hand hygiene to Resident #54 after she woke him from sleeping. During an interview on 4/1/2024 at 12:17 PM, CNA #12 confirmed she had not offered hand hygiene assistance to Resident #54 before she deivered the resident's lunch. Resident #79 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus and Hypertension. Review of a quarterly MDS assessment dated [DATE], showed Resident #79 had moderate cognitive impairment. During an observation on 4/1/2024 at 12:44 PM, Resident #79 was sitting near room [ROOM NUMBER] in the hall, when CNA #11 took him into the day room and set up the resident's lunch tray in front of Resident #79 without offering hand hygiene. During an interview at 12:45 PM, CNA #11 confirmed she did not offer hand hygiene to Resident #79 before he started to eat the lunch tray she delivered. During an interview on 4/1/2024 at 12:57 PM, the Director of Nursing (DON) confirmed it was her expectation that residents were offered hand hygiene assistance prior to meals with hand sanitizer or a washcloth with soap and water.