STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445319	A. Building B. Wing	07/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elk River Health & Nursing Center of Winchester	32 Memorial Drive Winchester, TN 37398

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility investigation documentation review, and interviews, staff failed to report an allegation of resident-to-resident abuse to administration for 1 resident (Resident #13) of 4 residents reviewed for abuse. The findings include:Review of the facility's policy titled, Abuse & Neglect Prohibition, revised 11/2017, revealed .The facility will report all allegations and substantiated occurrences of abuse .to the administrator .not later than 24 hours after being notified of the allegation .Review of the facility's policy titled, Abuse Prevention Policy & Procedure, revised 5/2023, revealed .If a resident-to-resident incident occurs .Notify the Director of Nursing and the Administrator immediately .Notify the physician and family/guardian .Reporting/Investigation/Response Policy .Any complaint, allegation, observation or suspicion of resident abuse, mistreatment .whether physical .involuntary or voluntary, is to be thoroughly reported, investigated and documented .All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty . Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses including Malignant Neoplasm of Vertebral Column, Diabetes Mellitus, and Generalized Anxiety Disorder. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #13 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Continued review of the MDS revealed no moods or behaviors were documented. Review of a comprehensive care plan dated 7/7/2025, revealed Resident #13 had no previous behaviors documented. Review of the medical record revealed Resident #67 was admitted to the facility on [DATE] with diagnoses including Dementia, Agitation, Anxiety, and Hypertension. Review of the medical record revealed the MDS assessment had not been completed for Resident #67 due to the recent admission date of 7/24/2025. Review of a baseline care plan dated 7/25/2025, revealed Resident #67 had no history of aggressive behaviors documented. During an interview on 7/28/2025 at 9:05 AM, the Administrator notified the State Survey Agency he had just been made aware of an allegation of a resident-to-resident altercation between Resident #13 (alleged victim) and Resident #67 (alleged perpetrator) by the Wound Care Licensed Practical Nurse (LPN) which had occurred on 7/27/2025. During an interview on 7/28/2025 at 9:35 AM, the Wound Care LPN stated she was providing care to Resident #13 when the resident informed her Resident #67 hit her in the head with her [Resident #13's] reacher (a tool used to grab objects up to 3 pounds-made of aluminum [NAME]) when she was asleep a few nights ago (actual occurrence 7/27/2025 at 2:00 AM). The Wound Care LPN stated she immediately informed the Administrator of the allegation. Review of the facility's incident report dated 7/28/2025, revealed on 7/27/2025 at approximately 2:00 AM, LPN A was notified by Certified Nursing Assistant (CNA) B Resident #67 hit Resident #13 on the head with a reacher. Resident #67 was removed from Resident #13's room and taken to the common area for 1:1 observation. Resident #13 was assessed with no injury or pain noted. LPN A did not feel the incident met the criteria of abuse because there were no injuries and did not report the incident to the Administrator or the DON. During a telephone interview on 7/28/2025 at 3:15 PM, CNA B stated she responded to Resident #13's call light on 7/27/2025 at approximately 2:00 AM. CNA B stated she entered the room and observed Resident #67 seated on Resident #13's bed and noticed the reacher on the bed. Resident #13 informed CNA B Resident #67 had struck her on the head with the reacher but the CNA did not observe the incident. CNA B stated LPN A entered Resident #13's room and she informed the LPN of the incident. Resident #67 was removed from the room by LPN A and was placed on 1:1 observation by staff for the duration of the shift. CNA B remained with Resident #13 until LPN A returned to the room and assessed Resident #13, who denied any pain or injury. During a telephone interview on 7/28/2025 at 3:30 PM, LPN A stated she was notified by CNA B at approximately 2:00 AM on 7/27/2025 of an incident between Resident #13 and Resident #67 as she was entering Resident #13's room. LPN A stated CNA B informed her Resident #67 sat on Resident #13's bed and then struck the resident over the head with the reacher. LPN A stated she removed Resident #67 from the room for 1:1 observation by staff. LPN A stated she assessed Resident #13 and Resident #67, neither had injuries and both denied pain. LPN A stated due to the residents not having any complaints, she did not consider the altercation abuse and did not report the incident to the Administrator or the DON. Review of an Incident Note for Resident #13 dated 7/27/2025 at 2:00 AM, revealed .Late Entry:[LPN A] reported that [Resident #67] was sitting on [Resident #13's] bed and had hit her over the top of her head with a reacher. [LPN A] removed Resident [Resident # 67] from her