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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 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 (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	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 room and brought her to the nurses' station. Resident [Resident #13] was assessed with no injuries noted .Review of an Initial Psychiatric Consult dated 7/28/2025, revealed Resident #67 .being seen today for an initial visit per social services and nursing staff request .A couple of nights ago, [Resident #67] wandered into [Resident #13's] room and sat at the foot of [Resident #13's] bed. [Resident #67] reportedly hit [Resident #13] over the head with a grabber stick .[Resident #13] was not injured and reports that nursing staff immediately intervened and redirected resident .She [Resident #67] is confused and completely disoriented to person, place, and time .During an interview on 7/28/2025 at 10:10 AM, Resident #13 stated a few nights ago Resident #67 came into the room and .hit me [Resident #13] in the head with my reacher . Resident #13 denied any pain or injury and stated she felt safe in the facility. Resident #13 stated she felt Resident #67 was just confused and did not mean to do it. Resident #13 stated she did not feel it was abuse or intentional and wished staff would just move on and stop asking questions about it.During an interview on 7/29/2025 at 2:45 PM, the Administrator stated the Wound Care LPN notified him of the incident between Resident #13 and Resident #67 on 7/28/2025. The Administrator stated while conducting the investigation he became aware the incident occurred Sunday morning (7/27/2025) at 2:00 AM. The Administrator stated he had not been notified of the event until Monday morning (7/28/2025, 1 day and 7 hours after the incident) at approximately 9:00 AM. The Administrator confirmed the allegations of abuse had not been reported by staff to administration timely. During an interview on 7/29/2025 at 3:05 PM, the DON stated she was made aware of the incident between Resident #13 and Resident #67 yesterday (Monday 7/28/2025 at 9:00 AM, 1 day and 7 hours after the incident) by the Wound Care LPN. The DON stated she immediately initiated an investigation, reported to the state and started obtaining witness statements. The DON confirmed the incident occurred on 7/27/2025 at 2:00 AM and LPN A failed to report the allegations to administration.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, Resident Assessment Instrument (RAI) Manual 3.0 review, medical record review, and interview, the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Resident #48) of 24 residents reviewed.The findings include:Review of the facility's policy titled, MDS Completion and Submission Timeframes, revised 7/2017, revealed .Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes .The Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted .in accordance with current federal and state guidelines .Review of the RAI Manual 3.0 dated 10/2024 revealed .Feeding Tubes .focuses on the long-term .use of feeding tubes .feeding tubes can be associated with diverse complications that may further impair quality of life or adversely impact survival .When this CAA [Care Area Assessment] is triggered, nursing home staff should follow their facility's chosen protocol or policy .This CAA is triggered when the resident has a need for a feeding tube for nutrition .Review of the medical record revealed Resident #48 was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including Diabetes Mellitus, Anoxic Brain Damage, and Vegetative State (with Percutaneous Endoscopic Gastrostomy (PEG) Tube (medical device inserted into the stomach through the abdominal wall, used for nutrition and medication).Review of the Physician's Orders for Resident #48 dated 9/20/2024, revealed enteral (a method of providing nutrition directly into the gastrointestinal tract when someone cannot eat or swallow) feed order two times a day via pump- Jevity 1.2 calories (cal) (liquid artificial nutrition) at 50 milliliters (ml) per hour for 22 hours daily via pump per PEG tube and water flush at 40 ml per hour. Review of a comprehensive care plan for Resident #48 dated 9/28/2024, revealed the resident required tube feedings related to an anoxic brain injury. Review of the annual MDS assessment dated [DATE], revealed Resident #48 was unable to complete a Brief Interview for Mental Status (BIMS) assessment due to severe cognitive impairment. Continued review revealed the MDS had not been coded for the use of a PEG tube. During an observation of Resident #48 on 7/28/2025 at 11:28 AM and on 7/29/2025 at 2:38 PM, in the resident's room, revealed the resident lying in bed with the head of the bed elevated 45 degrees with a PEG tube infusing via a pump with Jevity 1.2 cal at 50 ml and a water flush infusing at 40 ml per hour. During an interview on 7/29/2025 at 1:05 PM, the MDS Coordinator stated Resident #48 required use of a PEG tube for the primary means of nutrition, hydration, and medication. The MDS Coordinator confirmed the facility failed to accurately assess the resident's nutritional status for use of the PEG tube on the MDS assessment.During an interview on 7/30/2025 at 7:24 AM, the Director of Nursing (DON) stated Resident #48 had a PEG tube and confirmed the MDS was inaccurately assessed and coded for Resident #48.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, observation, and interview, the facility failed to revise the comprehensive care plan for 1 resident (Resident #3) of 16 residents reviewed for care plans. The findings include:Review of the facility's policy titled, Care Plans, Comprehensive Person-Centered, revised 12/2016, revealed .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident .Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change .The interdisciplinary Team must review and update the care plan .when the resident has been readmitted to the facility from a hospital stay .Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Liver Cirrhosis, Peptic Ulcer Disease, Diabetes, and Schizophrenia. Further review revealed Resident #3 was admitted to the hospital on [DATE] and returned to the facility on 4/29/2025 with diagnoses including Acute Gastrointestinal Bleed.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 15 on the Brief Interview for Mental Stats (BIMS) assessment which indicated Resident #3 was cognitively intact. Review of the current Physician's Orders for Resident #3 dated 7/30/2025, revealed orders for Lactulose (medication used to treat liver cirrhosis by reducing level of ammonia in the blood by trapping it in the colon, where it can eliminated) and rifaximin (antibiotic used to treat intestinal disorders including liver cirrhosis by preventing bacteria from growing and spreading).Review of the current Comprehensive Care Plan for Resident #3, dated 10/19/2024, revealed the facility failed to revise the care plan to include the diagnosis of Liver Cirrhosis, a condition which requires monitoring and treatment. Review of the History and Physical for Resident #3 from the local hospital for the hospitalization stay of 4/19/2025 to 4/29/2025, revealed Resident #3 was admitted to the hospital for an Acute Gastrointestinal Bleed which required a blood transfusion, and the discontinuation of anticoagulant medication (medication used to help prevent blood clotting).Review of the current Comprehensive Care Plan for Resident #3, dated 10/19/2024, revealed no documentation the care plan had been revised following Resident #3's hospitalization for the GI Bleed on 4/29/2025, the monitoring and treatment, or after the anticoagulant medication had been discontinued.Review of a document titled, Vision Orders, for Resident #3 dated 5/27/2025, revealed new findings of a right eye Retinal Detachment (condition where the tissue in back of eye pulls away from its normal position), requesting referral to a Retinal Specialist.Review of a document titled, TN Retina Visit for Resident #3 dated 7/22/2025, revealed the physician discussed plans for eye surgery with the resident who consented to the procedure. Review of Physician Progress Note for Resident #3 dated 7/28/2025, revealed the eye surgery was scheduled for 8/2025.Review of the current Comprehensive Care Plan for Resident #3, dated 10/19/2024 and revised 7/30/2025, revealed no documentation the care plan had been revised with the changes in condition requiring monitoring and treatment, with a new diagnosis on 5/27/2025 of the right eye retinal detachment or pending surgical procedure. Review of a Physician Progress Note for Resident #3 dated 7/18/2025, revealed Resident #3 reported bloody drainage from the right ear, and antibiotic Cefdinir was started to treat Otitis Media (inner ear infection).Review of the current Comprehensive Care Plan for Resident #3, dated 10/19/2024 and revised 7/30/2025, revealed no documentation the care plan had been revised with the changes in condition which required monitoring and treatment with antibiotics for the Otitis Media.Review of a document titled, US [ultrasound], Scrotum and contents, dated 7/16/2025, revealed an Ultrasound (an xray technique using sound waves to take pictures inside the body) of the scrotum was performed with findings of a lesion in the right testicle.Review of a Physician Progress (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Note for Resident #3 dated 7/18/2025, revealed an ultrasound was performed, with findings of a right testicular lesion suspected to be testicular cancer.Review of a Physician Progress Note for Resident #3 dated 7/28/2025, revealed new findings of a testicular mass.Review of the current Comprehensive Care Plan for Resident #3, dated 10/19/2024 and revised 7/30/2025, revealed no documentation the care plan had been revised with the changes in condition which required the monitoring and treatment of a new diagnoses of a testicular mass on 7/18/2025. During an interview on 7/30/2025 at 11:00 AM, the Director of Nursing (DON) confirmed the Comprehensive Care Plan for Resident #3 had not been revised to include the diagnosis of Liver Cirrhosis, the hospitalization for the GI bleed, the treatment of an ear infection, the new diagnoses of the retinal detachment and testicular mass and treatments.