

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445343	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Signature Healthcare of South Pittsburg Rehab & We		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East 10th Street South Pittsburg, TN 37380	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48100</p> <p>Based on facility policy review, medical record review, observations, and interviews, the facility failed to provide a homelike environment for 3 residents (Resident #73, Resident #40, and Resident #33) of 81 residents reviewed for a homelike environment.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, A Safe, Clean, Comfortable, and Homelike Environment, undated, revealed .the resident has a right to a .homelike environment .the facility provides .maintenance services necessary to maintain a sanitary, orderly, and comfortable interior .</p> <p>Review of the medical record revealed Resident #73 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Seizures, and Hemiplegia.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #73 scored a 9 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had moderate cognitive impairment.</p> <p>During an observation in room [ROOM NUMBER], on 10/16/2024 at 7:43 AM, revealed multiple areas of chipped paint, of various sizes, with the bottom trim baseboard peeling away from the wall below the air conditioning unit.</p> <p>Review of the medical record revealed Resident #40 was admitted to the facility on [DATE] with diagnoses including Heart Disease, Chronic Pain, and Dementia.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #40 had a memory problem and was severely impaired of cognitive skills for daily decision making.</p> <p>During an observation in room [ROOM NUMBER], on 10/16/2024 at 7:45 AM, revealed multiple areas of chipped paint, of various sizes, on the wall behind Resident #40's bed.</p> <p>Review of the medical record revealed Resident #33 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, and Anxiety.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #33 scored a 3 on the BIMS assessment which indicated the resident had severe cognitive impairment.</p> <p>During an observation in room [ROOM NUMBER], on 10/16/2024 at 7:48 AM, revealed multiple areas of chipped paint, of various sizes, on the wall behind Resident #33's bed. Further observation revealed multiple areas of chipped paint, of various sizes to the upper perimeter of the air conditioning unit.</p> <p>During an interview on 10/16/2024 at 8:05 AM, the Plant Director confirmed room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] did not reflect a homelike environment for Resident #40, Resident #73, and Resident #33 and the rooms (room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) needed repairs.</p>

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36534</p> <p>Based on facility policy review, medical record review, facility investigation review, observation and interview, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 residents (Resident #65 and Resident #6) of 13 residents reviewed for abuse. On 8/6/2024, Resident #6 grabbed Resident #65 by the shirt causing Resident #65 to turn over in his wheelchair causing scratches to the left shoulder, 3 skin tears to the left forearm, and a skin tear on the right hand to reopen. Resident #65 retaliated and struck Resident #6 in the face causing a laceration to the resident's right upper lip. The facility's failure to protect the residents' right to be free from physical abuse resulted in actual Harm for Resident #65 and Resident #6.</p> <p>The findings include:</p> <p>Review of a facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 9/15/2023, revealed .It is the organization's intention to prevent the occurrence of abuse .abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish .Instances of abuse of all residents irrespective of any mental or physical condition, cause physical harm, pain or mental anguish .It includes .physical abuse .</p> <p>Review of the medical record revealed Resident #65 was admitted to the facility on [DATE], with diagnoses including Depression, Anxiety Disorder, Osteoarthritis Right Shoulder, and Alcohol Dependence.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #65 scored 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Further review revealed Resident #65 had behaviors of rejection of care for 4 to 6 days during the assessment period with no other behaviors noted.</p> <p>Review of a Nurse's Note for Resident #65 dated 8/6/2024 at 7:30 AM, revealed .called to room by CNA [Certified Nursing Assistant]. Elder [Resident #65] observed laying supine in the floor by roommate's [Resident #6's] bed. Elder [Resident #65] states roommate [Resident #6] grabbed him by the shirt, would not let go, and eventually pulled him down into the floor. WC [wheelchair] was flipped over as well. T-Shirt noted to be ripped. Denies hitting his head. Scratches noted to left shoulder. Skin tears noted to right hand and left forearm. Elder also states he hit his roommate in the mouth several times with his fist when he would not let go of him. Head to toe assessment complete without further injury noted or C/O [complaint of]. Elder assisted back to WC x [times] 3 staff. Skin tears cleansed with NS [normal saline] and covered with a dry dressing per orders. Shirt changed. Denies further needs .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Nurse Practitioner's (NP) Note for Resident #65 dated 8/6/2024, revealed .Chief Complaint/History of Present Illness .Patient scheduled for visit following altercation with another resident [Resident #6] this morning. The patient [Resident #65] is [AGE] year-old male who was in an altercation with another resident [Resident #6] this morning. Patient sustained skin tears to upper extremities. Skin tears are currently bandaged, and dressing is clean dry and intact. Patient denies any other injuries or complaints other than skin tears at this time. Patient denies any acute concerns or needs at this time .No acute distress noted, cooperative, alert, and oriented x 3 [to person, place, and time] .New skin tears noted to upper extremities [right hand and left forearm] with dressing in place that are clean, dry, and intact .Skin tear of upper extremity .Nursing to complete wound care. Instructed patient that if he developed any additional or worsening symptoms following altercation to notify nursing for further evaluation .Patient verbalized understanding. Plan of care ongoing .</p> <p>Review of a facility investigation dated 8/6/2024, revealed the staff heard a commotion in the residents' (Resident #65 and Resident #6) room. When the nurse arrived to the room, Resident #65 was in the floor beside the roommate's (Resident #6's) bed and Resident #6 was lying sideways in the bed. The residents agreed that Resident #6 had pulled Resident #65 from his wheelchair by his shirt and would not let go. Resident #65 received skin tears and Resident #6 received a laceration to his upper lip. The residents were separated immediately, and Resident #6 was placed on one on one (supervision of 1 staff to 1 resident), was sent to the hospital for a medical clearance, for possible transfer to a Geriatric (Geri) Psychiatric (Psych) facility. However, there was not facility (Geri-Psych) availability at the time. Resident #6 was moved to another room (after return from the hospital's emergency room) and the staff stayed 1 on 1 for 48 hours, he was then placed on every 15-minute rounds after the 48 hours concluded.</p> <p>Review of a facility document titled, Event Report Skin Integrity, for Resident #65 dated 8/6/2024, revealed . Skin Tear/Laceration left lower arm X 3 skin tears, some scratches to left shoulder. 1 inch [skin tear #1], 0.5 inch [skin tear #2], 0.5 inch [skin tear #3] .controlled bleeding .wound edges smooth .no pain .resident to resident .monitor for signs/symptoms of infection to skin tears .to left arm Q [every] shift until healed .cleaned with normal saline and cover with dry dressing .</p> <p>Review of a comprehensive care plan for Resident #65 dated 8/6/2024, revealed the resident was involved in a resident-to-resident altercation and the roommate (Resident #6) was moved to a different room.</p> <p>Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Vascular Dementia with Behavioral Disturbance, Hemiplegia affecting Left Non-Dominant Side, Mood Disorder, Schizoaffective Disorder Bipolar Type, Intracranial Injury, and Compression of the Brain.</p> <p>Review of an annual MDS assessment dated [DATE], revealed Resident #6 scored 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed no behaviors were noted during the assessment period. The resident was dependent for transfers.</p> <p>(continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Review of a Nurse's Notes for Resident #6 dated 8/6/2024, revealed .Called to room by CNA. Elder's roommate [Resident #65] observed laying in the floor beside elder's bed. Elder states he [elicit word] [beat] [NAME] [Resident #65] up because he was wearing his shirt and wanted it back . Elder's roommate was not named [NAME] and the roommate [Resident #65] was not wearing elder's [Resident #6's] shirt. Head to toe assessment completed. Laceration noted to right upper lip with scant amount of bleeding. Laceration cleansed . bleeding stopped. Elder assisted into his WC x 2 staff and placed 1:1 [1 on 1] with nurse. Elder states 'bye [elicit name]!' as he is assisted out of room with nurse [speaking to Resident #65]. Elder continues to exclaim, 'I [elicit word] [NAME] up like a soup sandwich and I want to do it again! I am proud of myself, and my family would be too.' Elder believes '[NAME]' [roommate, Resident #65] is 'messaging around with Aunt [NAME] [Certified Nursing Assistant A, not related to Resident #6].' Elder cannot be re-directed at present. Neuro [neurological] checks completed. [baseline following traumatic brain injury (TBI)] .Elder transferred to [hospital] ER [emergency room] for medical eval [evaluation] at approximately 9:30 AM .</p> <p>Review of a facility document titled, Event Report Skin Tear/Laceration, for Resident #6 dated 8/6/2024, revealed .laceration .right upper lip .0.2 cm [centimeter] .controlled bleeding .no pain .behavioral outburst . first aide .monitor for signs/symptoms of infection Q shift .until healed .</p> <p>Review of a Physician's order for Resident #6 dated 8/6/2024, revealed .one on one .</p> <p>Review of a Physician's order for Resident #6 dated 8/6/2024, revealed .send to ER [emergency room] for medical clearance . (medical clearance by ER for possible transfer to a Geri-Psych unit for evaluation).</p> <p>Review of a Nurse's Note for Resident #6 dated 8/6/2024 at 12:19 PM, revealed .Elder [Resident #6] returned to facility at 11:35 AM, following being medically cleared at [hospital] .ER reports elder had negative CT [computerized tomography], baseline UDS [urine drug screen], and un-concerning labs. Also states elder calmed down initially but eventually became agitated when he 'wanted to come home.' Shortly after arrival, elder began yelling for '[NAME] to come down here so I can whoop your [elicit word]!' Other elder [Resident #65] (who has been moved temporarily) heard elder yelling down the hallway and became irritated and began cussing elder from doorway. Staff intervened again. Elder continues stating he wants to '[elicit word] [NAME] up again' and attempting to tear down his privacy curtain and bed rail .NP [Nurse Practitioner], notified with new orders for Haldol [antipsychotic medication] 5 mg (milligram) IM [intramuscular] now .</p> <p>Review of a comprehensive care plan for Resident #6 dated 8/6/2024, revealed the resident was involved in a resident-to-resident altercation, was placed on 1 on 1 monitoring and had a psychosocial follow-up for 72 hours. The residents (Resident #6 and Resident #65) were separated immediately.</p> <p>Review of a Nurse's Note for Resident #6 dated 8/8/2024 at 12:01 PM, revealed .NP seen pt [patient], no further behaviors noted, not combative at this time. new order to dc [discontinue] 1 on 1 and begin q 15 min [minute] checks at this time .</p> <p>Review of a Physician's order for Resident #6 dated 8/8/2024, revealed .every 15-minute checks .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a NP's Note for Resident #6 dated 8/21/2024, revealed .Patient is scheduled for routine follow-up and maintenance of chronic conditions .Patient [Resident #6] recently had exacerbation of schizoaffective disorder requiring additional doses of Haldol. Patient was sent to ER for medical clearance and referred to Geri psych. Patient was cleared medically. However, Geri psych referrals were declined due to patient's history of TBI. Following additional doses of Haldol patient returned to his baseline mental state. Patient is currently receiving Haldol 3 mg twice daily. Nursing denies any continued or worsening agitation since patient was placed on 15-minute checks .Positive for agitation and irritability but improved since altercation occurred . schizoaffective disorder, bipolar type .Continue haloperidol (Haldol) 3 mg twice daily. Will discontinue every 15-minute checks since patient's return to baseline mental state. Nursing to notify provider with any increased agitation .</p> <p>During an observation on 10/14/2024 at 10:20 AM, in the day room, Resident #6 was seated in a high back wheelchair, awake and alert, with no behaviors or concerns identified.</p> <p>During an interview on 10/14/2024 at 10:20 AM, Resident #6 initially stated he did not recall the incident (with Resident #65) and later stated .he [Resident #65] made me mad he was a talker he called me a [elicit name]. I tried to choke him to death, but he didn't hit me back . When asked if he recalled having a small cut to his lip he stated .I was so mad he might have hit me I just don't know . When asked if he had any further problems with Resident #65 or any other resident he stated No .he [Resident #65] isn't in my room any more .</p> <p>During an interview on 10/14/2024 at 10:40 AM, CNA A stated .I was both [provided care for Resident #6 and Resident #65] of their CNA that day [8/6/2024] .they were in their room, [Resident #6] was still in bed and [Resident #65] was in his wheelchair. I walked by and saw something had happened. [Resident #65] was on the floor, and his wheelchair was laying on its side .they were still exchanging words .[Resident #65] said he rolled by [Resident #6], and he grabbed him .[Resident #65] was out of the reach of [Resident #6] he can't get out of bed by himself, so I walked to the door and yelled at [Registered Nurse] (RN) B and the other nurse [Licensed Practical Nurse] (LPN) C came in too. They assessed [Resident #65] and got him out of the floor. [RN B] went to get bandages and I got [Resident #6] up and got him dressed and took him to the day room .[Resident #6] calls [Resident #65] [NAME] but that isn't his name .</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 10/14/2024 at 10:55 AM, RN B stated .they were roommates [Resident #6 and Resident #65] they had been known to exchange words but nothing ever aggressive before .it was mainly because [Resident #6] would call [Resident #65] [NAME] and get mad when [Resident #65] didn't answer . that day [8/6/2024] he thought [Resident #65] had on his T-shirt, but he didn't he had on his own shirt .it was just a plain white T-shirt .he also stated he thought [Resident #65] was fooling around with his Aunt [NAME] which is [CNA A] but he calls her Aunt [NAME]. [CNA A] hollered for me and said that [Resident #65] was in the floor. [Resident #6] was still in his bed he had his hand on the side rail, and he was just looking at [Resident #65]. I asked what happened and [Resident #65] stated that [Resident #6] had just grabbed him as he rolled by his [Resident #6's] bed he had grabbed him by the shirt and would not let him go .after we got them separated he [Resident #65] told me that he had hit [Resident #6] a couple of times in the mouth to get him [Resident #6] to let him [Resident #65] go .[Resident #65] said when he was pulling away from [Resident #6] that his wheelchair tipped over .[Resident #65] had a skin tear on his right hand .he had 3 or 4 superficial scratches a couple of inches long to his left shoulder and 3 new skin tears to his left forearm. I [RN B] cleaned them with normal saline and put on a dry dressing .[Resident #65] wasn't afraid or withdrawn he did tell me that he felt bad for retaliating because of [Resident #6's] disability .[Resident #6] did have a small cut to the top right lip. I cleaned it up, it wasn't bleeding .neither one of them complained of any pain .[Resident #65] didn't want to leave the room, he prefers to stay in his room and look at his phone or watch TV. So we got [Resident #6] up and dressed and took him to the day room .he likes to be in the day room, and spends most of his time in there .we were able to move [Resident #6] .both are monitored daily for behaviors . [Resident #6] had a couple of days that he was yelling out, but nothing after that .neither one of them has shown any aggressive behaviors after the incident, and I am not aware of any aggressive behaviors before the incident .</p> <p>During an observation and interview on 10/14/2024 at 11:30 AM, Resident #65 was awake, alert, and lying in bed watching TV. Resident #65 stated .[Resident #6] grabbed me by the shirt, he said it was his shirt but I got it out of my closet, it was my shirt .he [Resident #6] stretched my shirt and scratched me .he grabbed my wheelchair and when I was trying to get away from him my chair turned over .he is crippled but he's got a strong grip .I [Resident #65] wanted to hit him back but something told me not to since he is crippled and his mind isn't right .he is not all upstairs .no that is the only problem I have had with anybody .[no] he didn't hurt me I was able to brace myself when I fell .no I am not afraid of him .</p> <p>During an interview on 10/14/2024 at 9:25 AM, the Director of Nursing (DON) stated, .both residents [Resident #6 and Resident #65] admitted the incident occurred [on 8/6/2024] .the physical altercation was not witnessed by staff .we did send [Resident #6] out for medical clearance for in-patient psychiatric treatment, but after he was cleared we were not able to place him .we kept him on one on one care for 48 hours then on 15 minute checks until 8/24/2024, when the Nurse Practitioner saw him and discontinued the 15-minute checks due to no further behaviors. [Resident #65] did receive 3 small new skin tears to his left forearm and some small superficial scratches to his left shoulder. [Resident #6] did receive a small cut to his right upper lip .yes, both residents did receive minor injuries . During the interview the DON confirmed the facility failed to prevent abuse of Resident #65 and Resident #6, resulting in physical harm to both residents.</p> <p>49568</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568</p> <p>Based on facility policy review, medical record review, facility documentation review, resident financial statements review, and interviews, the facility failed to protect the residents' right to be free from misappropriation and/or exploitation when a staff member deliberately used multiple residents' personal monetary funds without consent for personal gain for 7 residents (Resident #16, Resident #55, Resident #69, Resident #25, Resident #54, Resident #52, and Resident #61) of 53 sampled residents reviewed for misappropriation of personal funds.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Abuse, Neglect and Misappropriation of Property, dated 9/15/2023, revealed .Misappropriation of Resident Property .defined as the deliberate .use of a resident's .money without the resident's consent .</p> <p>Review of the medical record revealed Resident #16 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Heart Failure, Epilepsy, and Diabetes.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #16 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #16, undated revealed .Resident #16's daughter brought concerns to the facility when she received a bill for patient liability in an amount over \$17, 000 .[Resident #16's daughter] .cancelled the debit card [for Resident #16] and requested 6 months of statements .[Resident #16's family] was able to get .bank statement which revealed a charge to a local carwash .[Resident #16's daughter] visited the carwash and found [former Business Office Manager] (BOM) used [Resident #16's] debit card to pay [at the local carwash] .[former BOM] was interviewed by the Administrator and Director of Nursing (DON) .[former BOM] admitted to using [Resident #16's debit card] [without consent] .[Resident #16] was interviewed by the Administrator and DON .[Resident #16] reported that she had given .[former BOM] her debit card so that she [former BOM] could make her payments [facility balances] and pick up items as needed .[Resident #16] believed that her patient liability was being paid [by the former BOM] .[facility] received [Resident #16's] bank statements back to May 2022 .Outstanding patient liability [bill] dates back to June 2022 .[Resident #16] reviewed all bank statements back to May 2022 and was able to verify the following expenditures one charge on 6/7/2024 at an ATM [Automated Teller Machine] for a cash withdrawal of \$30. An online store purchase on 7/16/2024 for \$164.61 .approved by [Resident #16] .</p> <p>Review of Resident #16's bank statements dated January 2024 through July 2024, revealed monthly transactions for cash purchases in the amount of \$32.99 at a local carwash each month which totaled \$230. 93. Further review revealed on 7/8/2024 an ATM cash withdrawal for \$300 was removed from Resident #16's bank account.</p> <p>Review of a witness statement for Resident #16 dated 7/30/2024, revealed .I [Resident #16] gave [former BOM] my [debit] card and she was supposed to pay my bill here [facility name] .I never gave [former BOM] permission to buy things for herself or to use my [debit] card without my knowledge .</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a letter from [Facility] to Resident #16 dated 8/26/2024, revealed .currently investigating the matter related to [Resident #16] receiving an outstanding bill for [from] the Facility .we [the facility] have notified the police, the Ombudsman, Adult Protective Services, and the [State Entity] . Facility did waive patient liability as of end of 7/2024 in the amount of \$18,760.00 and \$2,900.30 total reimbursement to Resident #16.</p> <p>Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Heart Disease, Heart Failure, and Hypertension.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #55 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #5, undated revealed .Resident #55 reports that she gave [former BOM] her debit card and [former BOM] would purchase a money order to pay Resident #55's liability to facility .debit card and copy of money order would be given back to .Resident #55 .Resident #55 believed patient liability was paid in full .provided copies of money orders as proof .facility was able to request information .money orders from post office .copies of money orders show that [former BOM] .making money orders out to herself [former BOM] .rather than paying Resident #55's patient liability .total of 13 money orders were made out to [former BOM] .total amount was \$7,520 .money orders associated with Resident #55 were made payable to [former BOM] .money order .10/20/2023 . \$1,000 .money order .10/20/2023 . \$80 .money order .12/11/2023 . \$860 .money order .1/19/2024 . \$116 .money order .1/19/2024 . \$1,000 .money order .4/19/2024 . \$1,000 .money order .4/19/2024 . \$116 .money order .5/20/2024 . \$1,000 .money order .5/20/2024 . \$116 .money order .6/13/2024 . \$1,000 .money order .6/13/2024 . \$116 .money order .7/16/2024 . \$1,000 .money order .7/16/2024 . \$116 .after reviewing outstanding accounts receivable and money orders provided as proof of payment .</p> <p>Review of a letter from [facility] to Resident #55 dated 8/27/2024, revealed .currently investigating the matter related to payments made, or potentially not made, on your monthly bill for the facility .notified the police, the Ombudsman, Adult Protective Services, and the [State Entity] . Facility did waive outstanding balance patient liability for Resident #55 as of 7/2024 in the amount of \$9,366.45.</p> <p>Review of the medical record revealed Resident #69 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Hypertension and Irritable Bowel Syndrome.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #69 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #69, undated revealed, .Resident #69 communicated that [former BOM] informed Resident #69 that her purse and wallet were placed in storage . Resident #69 reports having questioned [former BOM] about the purse and debit card and was told that it was no longer in storage .bank statements were reviewed for 4/2024 through 7/2024 .ATM cash withdrawals equaled \$3,332.54 .Three money orders were located that had [Resident #69's] name on them and were made out to [former BOM] for a total amount of \$2,768.00 .Resident #69 received her bank statement which shows ATM withdrawals as late as 8/5/2024 for \$352 and 8/12/2024 in the amount of \$92 .The following money orders associated with Resident #69 were made payable to [former BOM] .Money order .7/21/2023 . \$960 .Money order .8/8/2023 . \$1,000 .Money order .10/18/2023 . \$808 .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Signature Healthcare of South Pittsburg Rehab & We		STREET ADDRESS, CITY, STATE, ZIP CODE 201 East 10th Street South Pittsburg, TN 37380	
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of a letter from [facility] to Resident #69 dated 8/27/2024, revealed .currently investigating the matter related to charges made, and potentially not made, on your debit card .we have notified the police, the Ombudsman, Adult Protective Services, and the [State Entity] . Facility did waive outstanding patient liability as of end 7/2024 in the amount of \$21,207.03 and reimbursed the resident for ATM withdrawals in the amount of \$444.</p> <p>Review of the medical record revealed Resident #25 was admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including Heart Failure, Hypertension, and Anemia.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #25 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #25, undated revealed, .Resident #25's family manages her finances .Resident #25 was interviewed and explained that her sister receives her [Resident #25] check and then brings cash to the facility to pay her rent .Resident #25's sister would give the money to [former BOM]. Resident #25 believed that her account was up to date .facility records indicate that some months were paid by credit cards and some months with money orders .Resident #25 has outstanding balance of \$6,074.91 .</p> <p>Review of a letter from [facility] to Resident #25 dated 8/27/2024, revealed .currently investigating the matter related to payments that were supposed to have been made on your monthly bill for the Facility .we have notified the police, the Ombudsman, Adult Protective Services, and the [State Entity] . Facility did waive outstanding patient liability as of end of 7/2024 in the amount of \$6,074.91.</p> <p>Review of the facility's investigation documentation for Resident #16, Resident #55, and Resident #68, undated revealed, .[Former BOM] admits to having Resident #16's debit card and using it to purchase the car wash subscription .copies of money orders show that [former BOM] was making the money orders out to herself rather than crediting it to [Resident #55's] account .total of money orders found equals \$7,520 .copies of money orders show that [former BOM] was making money orders out to herself rather than crediting it to [Resident #69's] account .total of money orders found equals \$2,768 .</p> <p>Review of the medical record revealed Resident #54 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Acute Pulmonary Edema, Hypotension, Dependence on Renal Dialysis, and Diabetes Mellitus.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #54 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #54 dated 9/18/2024, revealed .social security checks that had been mailed to the facility [for Resident #54] and not received .issue [facility not receiving the social security checks] was reported to all legal entities .including law enforcement, APS, Ombudsman, and [State Entity] .[Resident #54] [social security check in the amount of] \$1,429.00 deposited and cleared 9/10/2024 [not credited to the resident's liability] .called social security and indicated trace would be placed on cashed check .stated they cannot fax copy of the cashed check but can mail them .</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's investigation documentation for Resident #54 dated 10/8/2024, revealed .after not receiving copy of the cashed check [social security check] follow-up call was made to social security .stated they [social security] would look into it and call back .</p> <p>Review of the medical record revealed Resident #52 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Alzheimer's Disease, Hypertension, and Seizures.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #52 scored a 2 on the BIMS assessment which indicated the resident had severe cognitive impairment.</p> <p>Review of the facility's investigation documentation for Resident #52 dated 9/18/2024, revealed .social security checks that had been mailed to the facility and not received .issue [facility not receiving the social security checks] was reported to all legal entities .including law enforcement, APS, Ombudsman, and [State Entity] .[Resident #52] [social security check in the amount of] \$1,510.00 deposited and cleared 9/9/2024 [not credited to the resident's liability] .called social security and indicated trace would be placed on cashed check .stated they cannot fax copy of the cashed check but can mail them .</p> <p>Review of the facility's investigation documentation for Resident #52 dated 10/8/2024, revealed .after not receiving copy of the cashed check [social security check] follow-up call was made to social security .stated they [social security] would look into it and call back .</p> <p>Review of the medical record revealed Resident #61 was admitted to the facility on [DATE] with diagnoses including Complete Traumatic Amputation of Left Lower Leg, Diabetes Mellitus, Acquired Absence of Right Leg Above Knee, and Hypertension.</p> <p>Review of a quarterly MDS assessment dated [DATE], revealed Resident #61 scored a 13 on the BIMS assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation documentation for Resident #61 dated 9/18/2024, revealed .social security checks that had been mailed to the facility and not received .issue [facility not receiving the social security checks] was reported to all legal entities .including law enforcement, APS, Ombudsman, and [State Entity] .[Resident #61] [social security check in the amount of] \$1,014.00 deposited and cleared 9/13/2024 [not credited to the resident's liability] .called social security and indicated trace would be placed on cashed check .stated they cannot fax copy of the cashed check but can mail them .</p> <p>Review of the facility's investigation documentation for Resident #61 dated 10/8/2024, revealed .after not receiving copy of the cashed check [social security check] follow-up call was made to social security .stated they [social security] would look into it and call back .</p> <p>During an interview on 10/16/2024 at 7:35 AM, the Director of Nursing (DON) revealed the former BOM was in possession of Resident #16's debit card and did admit to monthly car wash subscription charges and taking \$300 out of the ATM without Resident #16's consent. The DON confirmed Resident #16, Resident #55, Resident #69, and Resident #25 had their debit cards misused, had unauthorized money orders made out to the former BOM, and the residents' funds were unaccounted. The DON stated the facility's investigation outcome was that the former BOM had mishandled residents' funds and the incident had been reported to the police, Ombudsman, Adult Protective Services, and the [State Entity].</p> <p>(continued on next page)</p>		

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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 10/16/2024 at 8:45 AM, the Regional BOM revealed Resident #54, Resident #52, and Resident #61's social security checks were mailed to the facility, checks were cashed, and were not credited to the facility.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407</p> <p>Based on facility policy review, Resident Assessment Instrument (RAI) Manual 3.0 review, medical record review, and interviews the facility failed to accurately complete a Minimum Data Set (MDS) assessment for 1 resident (Resident #55) of 20 residents reviewed for accuracy of MDS assessments.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Comprehensive Care Plan, revised 2/9/2024, revealed .The facility will develop and implement a comprehensive person-centered care plan for each resident that .meet a resident's medical .nursing .psychosocial needs that are identified in the comprehensive assessment .</p> <p>Review of the RAI Manual 3.0 dated 10/2023, revealed .Hospice care .Code residents identified as being in a hospice program .for management of terminal illness .</p> <p>Review of the medical record revealed Resident #55 was admitted to the facility on [DATE] with diagnoses including Convulsions, Prescence of Cardiac Pacemaker, and Heart Failure.</p> <p>Review of a Physician's Order for Resident #55 dated 8/23/2023, revealed .Hospice care .</p> <p>Review of a comprehensive care plan for Resident #55 revised 8/23/2023, revealed .hospice services .</p> <p>Review of an annual MDS assessment for Resident #55 dated 9/4/2024, revealed the MDS assessment was not coded for hospice services.</p> <p>During an interview on 10/15/2024 at 2:28 PM, Licensed Practical Nurse (LPN) C stated Resident #55 received hospice care services.</p> <p>During an interview on 10/16/2024 at 8:57 AM, the MDS Coordinator confirmed Resident #55 received Hospice services and the annual MDS assessment dated [DATE] was inaccurate.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50407</p> <p>Based on facility policy review, medical record review, observation, and interviews the facility failed to follow infection control practices during medication administration for 1 resident (Resident #59) of 3 residents observed for medication administration.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, Policies and Practices-Infection Control, undated, revealed .This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary .environment .to help prevent and manage transmission of diseases and infections .for .residents .</p> <p>Review of the medical record revealed Resident #59 was admitted to the facility on [DATE] with diagnoses including Osteomyelitis of Lower Left Extremity, Need for Personal Assistance with Personal Care, and Diabetes.</p> <p>During an observation of medication administration on 10/15/2024 at 7:31 AM, Licensed Practical Nurse (LPN) D donned gloves and prepared medications for Resident #59. Further observation revealed LPN D dropped 1 tablet of Gabapentin [medication used to treat chronic pain] 100 milligram (mg) on the surface of the medication cart. LPN D picked up the tablet and placed the tablet in a medication cup. LPN D continued to prepare the remaining scheduled medications for Resident #59, placed the medications in the same medication cup, and administered the medications to Resident #59.</p> <p>During an interview on 10/15/2024 at 1:51 PM, LPN D confirmed she dropped the Gabapentin 100 mg tablet on top of the medication cart and confirmed the medication should have been discarded and not administered to Resident #59.</p> <p>During an interview on 10/16/2024 at 9:10 AM, the Director of Nursing (DON) confirmed LPN D did not follow standard precautions with facility infection control practices during medication administration.</p>		