STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holston Health & Rehabilitation Center	3916 Boyds Bridge Pike Knoxville, TN 37914

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50480 Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to ensure 1 resident (Residents #51) was free from physical abuse when 1 resident (Resident #84) hit Resident #51 on the left arm of 81 residents sampled for abuse. The findings include: Review of the facility's policy titled, Patient Protection and Response policy for Allegation/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated 2/1/2023, revealed .Abuse .will not be tolerated by anyone .including .patients .The patient has the right to be free from abuse .Abuse .includes .physical abuse .Willful .as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .Physical Abuse .includes hitting .slapping . Review of the medical record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses including Dementia, Adult Failure to Thrive, Anemia, and Palliative Care. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #51 scored a 12 on the Brief Interview for Mental Status (BIMS) assessment, which indicated the resident had moderate cognitive impairment. Further review of the quarterly MDS assessment revealed Resident #51 utilized a wheelchair for mobility. Review of the Nursing Progress Notes for Resident #51 dated 6/20/2023 at 11:32 PM, revealed .Notified by . [CNA C-certified nursing assistant] .the resident [Resident #51] was in her room when another resident [Resident #84] came in to get .shoes [Resident #84 thought Resident #51 had taken her shoes] .when [Resident #51] refused to give [Resident #84] the shoe [Resident #84] hit [Resident #51] on the left arm . Assessed resident for injury .Resident denies any pain . Review of the Nursing Progress Notes for Resident #51 dated 6/21/2023 at 1:50 PM, revealed .Left arm w/ [with] no bruising .no c/o [complaints] of pain or discomfort . Review of the medical record revealed Resident #84 was admitted to the facility on [DATE], with diagnoses including Adult Failure to Thrive, Altered Mental Status, Depression, Adjustment Disorder, Dementia with Severe Agitation, Mood Disturbance, and Anxiety. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #84 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. Further review revealed Resident #84 utilized a wheelchair for mobility and exhibited no behaviors. Review of a comprehensive care plan for Resident #84 dated 4/27/2023, revealed .Behavioral Symptoms . Wandering in hallway and [in] other patients [patients'] rooms .Approach [intervention] .Direct resident to safe activities .Guide patient back .if she is self-propelling in a wheelchair . Review of the Nursing Progress Notes for Resident #84 dated 6/20/2023 at 10:00 PM, revealed .[CNA C] . reported that she was in [Resident #51's room] when [Resident #84] came into [Resident #51's room] accused [Resident #51] of taking her [Resident #84] shoes and hit her [Resident #51] on the left arm . Promptly removed .[Resident #84] from [Resident #51's] room . Review of a witness statement dated 6/20/2023, revealed .[Resident #51] was sitting in her wheelchair in her room .[Resident #84] was very aggravated about her [Resident #84's] shoes came in [Resident #51's room] saying [Resident #51] had her shoes .and smacked [Resident #51] on her left arm . Further review revealed CNA C signed the witness statement. Review of the Nursing Progress Notes for Resident #84 dated 6/20/2023 at 10:00 PM, revealed .Resident transported to [name of hospital] for evaluation . Resident #84 was placed in 1 on 1 supervision until transferred to the hospital. Review of the Hospital Progress Note for Resident #84 dated 6/21/2023 at 2:04 PM, revealed the resident presented to the Emergency Department (ED) with agressive behaviors. While in the ED, Resident #84 was diagnosed with an Urinary Tract Infection (UTI), treated with antibiotics, and once her behaviors stabilized was transferred back to the long term care facility. Review of the Nursing Progress Notes for Resident #84 dated 6/21/2023 at 11:51 PM, revealed .Returned to facility .order for Cephalexin [medication used to treat UTI] 500 mg [milligram] every 8 hours for 5 days for UTI . Review of the Nurse Practitioner Progress Notes for Resident #84 dated 6/22/2023 at 1:43 PM, revealed Resident #84 was evaluated after a return visit from the ED for agressive behaviors and hitting Resident #51. During an interview on 12/11/2024 at 9:15 AM, Licensed Practical Nurse (LPN E) stated she was familiar with Resident #84 and recalled the resident versus resident altercation between Residents #51 and #84 which occurred on 6/20/2023, but did not witness the altercation. LPN E stated CNA C reported Resident #84 wandered into Resident #51's room and swatted Resident #51 on the left arm. LPN E stated Resident #51 recalled the event the night of the incident and denied pain after the altercation. LPN E stated Resident #84 was placed with 1 on 1 supervision until Emergency Medical Services (EMS) arrived to transport the resident to the hospital. LPN E stated Resident #84 did not exhibit behaviors towards other residents prior to or after the incident on 6/20/2023. During an interview on 12/11/2024 at 11:10 AM, the Administrator stated he was aware of a resident-versus-resident altercation between Resident #51 and Resident #84. The facility initiated an investigation and based on CNA C's witness statement the resident-versus-resident altercation between Resident #51 and Resident #84 had occurred.

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F 0602

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Protect each resident from the wrongful use of the resident's belongings or money.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 48100

Based on facility policy review, medical record review, facility documentation review, and interviews, the facility failed to protect the resident's right to be free from misappropriation and/or exploitation when a staff member deliberately used a resident's personal monetary funds without consent for personal gain for 1 resident (Resident #287) of 81 sampled residents reviewed for misappropriation of personal funds.

The findings include:

Review of the facility's policy titled, Patient Protection and Response Policy for Allegations/Incidents of Abuse, Neglect, Misappropriation of Property and Exploitation, dated 2/1/2023, revealed .the patient had the right to be free from abuse .misappropriation of property .definitions .misappropriation of property: the deliberate misplacement .temporary or permanent use of a patient's belongings or money without the patient's consent .

Review of the medical record revealed Resident #287 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Chronic Kidney Disease, and Malnutrition. Further review revealed the resident discharged home on 12/22/2022.

Review of the Activities of Daily Living (ADL) documentation for Resident #287 dated 12/15/2022 through 12/22/2022, revealed Certified Nursing Assistant (CNA) A cared for Resident #287 on the following dates: 12/16/2022, 12/20/2022, 12/21/2022, and 12/22/2022.

Review of a 5-day Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #287 scored a 14 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.

Review of the facility's documentation dated 1/24/2023, revealed the facility reported the following information to the state designated authority: .allegation type .misappropriation of resident property .staff became aware of the incident .1/24/2023 at 1:00 PM .alleged victim [Resident #287] .alleged perpetrator [CNA A] .relationship to the alleged victim .caregiver .date and time when alleged incident occurred . 12/20/2022 at 2:17 PM [date and time checks were cashed/deposited] .victim [Resident #287] called the facility today with a representative from her bank to report that two checks [amount unknown] had been cashed and the name on the check was a staff member [CNA A] .

Review of a police report dated 1/24/2023, revealed .offenses .theft from building .complainant [Resident #287] .suspects [CNA A] .properties .check .value: $525.00 .case notes .on 1/24/2023 .complainant .report [reported] that two checks were stolen out of her purse .the victim was at [facility name] from 12/15/2022 to 12/22/2022 .the suspect [CNA A] was the victim's CNA and had been in the room multiple times .at one point the suspect told the victim her [Resident #287's] purse had fallen off the table and she [CNA A] had picked up the contents and put it back [inside the purse] .the victim was notified by her bank that two of her checks were deposited at [bank name] .made out to the suspect [CNA A] .

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's investigation summary dated 1/27/2023, revealed .patient [Resident #287] discharged from facility on 12/22/2022 .on 1/24/2023 [bank representative and Resident #287] called [the Administrator] about 2 checks that were written and fraudulent in nature while [Resident #287 was a patient at the facility] . the employee involved [CNA A] was immediately placed on administrative leave .on 1/27/2023 [CNA A] resigned via [by way of] phone call with [the] Administrator . Review of a Facility Action and Abuse Report dated 5/2023, revealed CNA A was added to the abuse registry for abuse: exploitation. During an interview on 12/11/2024 at 8:28 AM, the Administrator stated Resident #287 and her bank representative called the facility on 1/24/2023 (specific time unknown) to inform the facility of an occurrence of check fraud which involved a staff member. The bank representative stated Resident #287 had 2 personal checks written out to CNA A and was cashed. The Administrator stated the bank reimbursed the resident the money stolen by CNA A. The Administrator stated CNA A was placed on administrative leave pending investigation however she called the Administrator back on 1/27/2023 to immediately resign. The Administrator stated during a follow up phone call with Resident #287, the resident had told him she remembered CNA A one night (date and time unknown) awakened and observed CNA A looking through her purse. The resident stated she asked CNA A what she was doing, and CNA A responded to Resident #287 that her [Resident #287's] purse fell on to the floor, and she (CNA A) was placing the contents back inside the purse. The Administrator stated Resident #287's two personal checks were stolen and cashed by CNA A sometime during the resident's stay in December 2022 however the resident was not aware of the missing funds until she received her bank statement in January 2023. The Administrator stated Resident #287 recognized the employee's name [CNA A] when the bank representative told her the name the checks were written out to and initiated a fraud alert on her bank account. The Administrator confirmed the facility failed to protect Resident #287 from a deliberate act of misappropriation of property when CNA A had taken 2 personal checks for personal gain without Resident #287's consent. Interview with the Administrator on 12/11/2024 at 9:18 AM, confirmed the facility had identified the misappropriation of property to Resident #287 and had taken actions to correct the non-compliance. A plan of correction was developed from 1/24/2023-2/1/2023 to address the deficient practice identified. The corrective actions were validated on-site by the surveyor on 12/9/2024-12/11/2024 through interviews and review of facility documents. The facility's Plan of Correction for the Freedom of Abuse, Neglect, and Exploitation dated 1/27/2023, was presented to the survey team and documented the following corrective actions were implemented: On 1/24/2023, interviews were conducted by the Social Services Director and with all residents (and or their responsible parties) to inquire for any items that may have been lost or stolen. Results concluded no other patients were identified as having any checks or money missing. On 1/24/2023-2/1/2023, the 75 active employees received education to address financial exploitation and misappropriation of resident property. Audits for any allegation of misappropriation of property of sampled residents were completed by the Administrator or designee on 3/2023-6/2023 and confirmed there were no issues observed with misappropriation of property. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Surveyor interviewed the Administrator on 12/11/2024 at 9:18 AM, in the Administrator's office. Interview confirmed there had not been any further incidents involving misappropriation of resident property or exploitation. 2. Surveyor interviewed multiple staff members (in various departments) from 12/9/2024-12/11/2024 for knowledge of the in-services provided in the corrective action plan, and no knowledge deficits were identified. The deficient practice was cited as past noncompliance for F-602 and the facility is not required to submit a plan of correction.