STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445351	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Greeneville	106 Holt Court Greeneville, TN 37743

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 - 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** 36003 Based on facility policy review, medical record review, facility investigation documentation review, police report review, observation, and interview, the facility failed to protect the residents' right to be free from physical abuse from another resident for 10 residents (Residents #23, #11, #14, #8, #1, #5, #26, #27, #25, and #36) of 37 residents reviewed for abuse. The facility's failure to protect the residents' right to be free from abuse resulted in actual HARM for Resident #23, #11, and #14. On [DATE], Resident #23 sustained a bruise and laceration to the forehead when Resident #13 threw a plastic bowl and hit Resident #23 on the right side of the forehead. On [DATE], Resident #11 sustained a scratch on the left lower jaw when Resident #12 hit Resident #11 on her left lower jaw. On [DATE], Resident #14 sustained a bite and significant bruising to the left forearm when Resident #15 bit Resident #14 on the to the left forearm. The findings include: (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 - Actual harm Residents Affected - Few	Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised on [DATE], revealed .It is the organizations intention to prevent the occurrence of abuse .and to assure that all alleged violations of federal or State laws which involved abuse .are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law .the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation .Abuse .the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .includes verbal abuse, sexual abuse, physical abuse, and mental abuse .Physical abuse .Includes, but is not limited to, hitting, slapping, pinching, kicking .or any similar touching of a resident that does not have an appropriate therapeutic purpose, and that is not reasonable related to the appropriate provision of ordered care and services .Allegation of Abuse .Means a report, complaint, grievance, statement, incident, or other facts that a reasonable person would understand to mean that abuse .is occurring, has occurred, or plausibly might have occurred .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .The identification, ongoing assessment, care planning for appropriate interventions, and monitoring of residents with needs and behaviors which might lead to conflict .Investigation Guidelines .The Facility Administrator will investigate all allegations, reports, grievances and incidents that potentially could constitute 'allegations of abuse,' .the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident .The Facility Administrator will make reasonable efforts to determine the root cause of the alleged violation and will implement corrective action consistent with the investigation findings and take steps to eliminate any ongoing danger to the resident or residents .Protection .If a suspected perpetrator is anyone other than a Stakeholder, the Facility Administrator or designee, will immediately take all appropriate measures to secure the safety and well-being of the affected resident or residents . Review of the facility policy titled Abuse, Neglect and Misappropriation of Property, revised [DATE], revealed . It is the organization's intention to prevent the occurrence of abuse, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law .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 .Physical abuse Includes, but is not limited to, hitting, slapping, pinching, kicking, controlling behavior through corporal punishment, or any similar touching of a resident that does not have an appropriate therapeutic purpose, and that is not reasonably related to the appropriate provision of ordered care and services .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur . Investigation Guidelines .The Facility Administrator will investigate all allegation, reports, grievance, and incidents that potentially could constitute allegations of abuse .The Facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	1. Review of the medical records and facility investigation documentation revealed a resident to resident altercation occurred between Resident #23 and Resident #13 on [DATE]. The incident of resident to resident abuse resulted in actual HARM to Resident #23 who sustained a laceration and bruise when Resident #13 threw a plastic bowl and hit Resident #23 in the forehead. Review of the medical record revealed Resident #23 was admitted to the facility on [DATE] with diagnoses including Dementia with Other Behavioral Disturbance, Generalized Anxiety Disorder (GAD), and Major Depressive Disorder. The resident expired on [DATE]. Review of the weekly skin assessment for Resident #23 dated [DATE], revealed the resident had no skin impairment. Review of the Nursing Progress Notes for Resident #23 dated [DATE] at 8:56 PM, revealed the resident had been involved in an altercation with another resident (Resident #13).Staff heard verbal confrontation [argument] from room [Resident #13 and Resident #23's room] and entered immediately. Staff observed [Resident #23] sitting in her w/c [wheelchair] and a small superficial laceration [small cut] to [Resident #23] forehead. A bowl was observed on floor next to w/c and watermelon pieces on [Resident #23's] lap. [Resident #23] states roommate had thrown a bowl at her. Residents were immediately seperated [separated] and head to toe assessment was complete. No other sign of injury noted. Laceration was cleansed and covered with bandaide [bandaid]. [Resident #23] denies any pain at this time. [Resident #23] unable to recall details r/t [related to] dx [diagnosis] of dementia. Resident [23] moved to [another room] at this time for separation [separation]. Resident [#23] pleasant mood at this time sitting in w/c at nurses [nurse's] station and no emotional distress or concerns observed . Review of a police report dated [DATE] at 8:13 PM, revealed officers were dispatched to the facility where the Director of Nursing (DON) reported there had been an altercation between 2 residents. The victim (Resident #23) and the suspect (Resident #13) could not remember what had happened. Continued review revealed Resident #23 had told a nurse that Resident #13 had .thrown a fruit cup at her striking her in the head, causing a small cut . Review of a Certified Nursing Assistant (CNA) Skin Care Assessment Sheet for Resident #23 dated [DATE], revealed the resident had a laceration on the left side of her forehead. Review of the Nurse Practitioner (NP) Note for Resident #23 dated [DATE], revealed the resident had . sustained a laceration to her left forehead .after her roommate threw a plastic bowl from dietary at her. The area was dressed with Steri-Strips [strips of tape put across a minor cut] .She has profound Dementia and has no recollection of what happened last evening .Today she has bruising [on forehead] . Review of the Social Services Progress Notes for Resident #23 dated [DATE] and [DATE], revealed the resident did not display any signs of anger, depression, or anxiety. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #23 scored a 00 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. The resident had not exhibited aggressive behaviors toward herself or others. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the NP Psychiatric Evaluation for Resident #23 dated [DATE], revealed the resident had been involved in an altercation with her roommate (Resident #13).Resident #23 was unable to recall details no recall of altercation. No signs or symptoms of worsening depression, known worsening anxiety, agitation no noted related distress resident is pleasant cooperative denies being fearful . Review of the medical record revealed Resident #13 was admitted to the facility on [DATE] with diagnoses included Dementia with Other Behavioral Disturbance, Generalized Anxiety Disorder (GAD), and Major Depressive Disorder (MDD). The resident expired on [DATE]. Review of a quarterly MDS assessment dated [DATE], revealed Resident #13 scored a 9 on the BIMS assessment which indicated the resident had moderate cognitive impairment. The resident had not exhibited aggressive behaviors toward other residents. Review of the Nursing Progress Notes for Resident #13 dated [DATE] at 8:44 PM, revealed .[Resident #23] noted to be involved in a resident to resident altercation. Resident's seperated [separated] immediately . [Resident #13] was placed on 1:1 [1 staff assigned to Resident #13 for monitoring] supervison [supervision]. [Resident #13] head to toe assessment complete and no s/s [signs or symptoms] of any injury or concern noted . Review of a comprehensive care plan for Resident #13 dated [DATE], revealed .Behavioral .Resident demonstrates inappropriate behaviors including increased agitation. History of resident to resident altercation and throwing objects at roommate .Assist resident .away from other residents as needed .Determine the cause for inappropriate behavior and refer to a provider for intervention .Encourage participation in structured activities as appropriate .Observe triggers of inappropriate behaviors and alter environment as needed . Observe for unmet needs such as .companionship . Review of the Social Services Progress Notes for Resident #13 dated [DATE], revealed the resident stated . she was doing fine and was relieved her roommate was not in there w/ [with] her now. [Resident #13] stated she's had a lot of emotions lately that have built up and her roommate tends to [NAME] at her about things. Resident stated she did throw the newspaper and the bowl but never intended on the bowl making contact w/roommate. Resident stated she was very sorry about that and expressed remorse over the incident . [Resident #13] did not display any anger, depression or anxiety. No behaviors noted at this time . Review of the Social Services Progress Notes for Resident #13 dated [DATE], revealed the resident did not display anger, depression, or anxiety. Review of the Psychiatric Evaluation for Resident #13 dated [DATE], revealed the resident was involved in an altercation with her roommate. Continued review revealed the resident had no evidence of increased anxiety, agitation, or worsening depression. Resident #13 was being treated for a Urinary Tract Infection. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the facility's investigation documentation dated [DATE] at 6:52 PM, revealed .On this date [[DATE]], [Resident #13] and current roommate [Resident #23] began to argue [in the resident's room] and [Resident #13] allegedly threw a plastic bowl, hitting roommate in the head .resulted in a small superficial laceration to [Resident #23's] forehead .Resident [Resident #13] stated she became frustrated with roommate repetitively asking her for the newspaper . The residents were immediately separated. Resident #23 was placed on 1:1 supervision for 24 hours, then every 30 minute checks until she was moved to a private room on [DATE]. Resident #13 was moved to another room on [DATE] for 48 hours, then returned to her original room on [DATE], after Resident #23 had been moved to a private room. Continued review revealed the incident occurred in Resident #13's and Resident #23's room. Review of the witness statement by CNA R dated [DATE], revealed CNA R heard Resident #13 tell Resident #23 to shut up followed by something hitting the floor. CNA R entered the residents' room (Resident #13 and Resident #23) and observed a cup on the floor and blood .running down [Resident #23's] face .[Resident #13] kept saying she didn't do it . Review of the witness statement by Licensed Practical Nurse (LPN) U dated [DATE], revealed a CNA informed her that Resident #13 had thrown a cup at Resident #23's head and Resident #23's head was bleeding. LPN U entered the resident's room and .Resident #23 had blood coming down her face w/ a laceration to the left side of her forehead .When I [LPN U] asked [Resident #23] what had happened she stated 'She [Resident #13] hit me w/ her cup'. I observed watermelon on [Resident #23's] cheek & [and] pants. When [Resident #13] was asked what happened [Resident #13] stated 'She was being mean & if I really wanted to hurt her I would of threw the book at her .it's all about [Resident #23]' and [Resident #13] started to laugh . Review of the witness statement by CNA V dated [DATE], revealed CNA V .heard [Resident #13] yell at [Resident #23] shut up shut up and immediately after [Resident #23] cried out she hit me with a cup I [CNA V] went in [Resident #23] was bleeding [Resident #13] was laying in bed missing her fruit bowl off her tray . [Resident #13] was talking meanly and smiling and laughing about hitting [Resident #23] with a cup [Resident #23] also had watermelon all over her . During a telephone interview on [DATE] at 5:09 PM, CNA R stated .I could hear Resident #13 yelling shut up to Resident #23 .heard noise and heard [Resident #23] crying .I saw the cup on the ground .Resident #23's face was slowly being covered with blood .the blood was coming from her forehead above her eyebrow . During an interview on [DATE] at 10:48 AM, the Social Services Director stated Resident #23 had a small bruise on her forehead, but the resident stated she was not experiencing pain. Continued interview revealed the resident exhibited no signs of anger, distress, or anxiety. During an interview on [DATE] at 11:45 AM, the NP confirmed Resident #23 sustained a laceration to her left forehead from a plastic food bowl thrown by Resident #13. Continued interview revealed Resident #23 had a bruise and mild hematoma (blood under skin) on [DATE]. The NP stated Resident #23 had no psychosocial effects from the altercation which occurred on [DATE]. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 2:15 PM, the Administrator, in presence of the DON and Registered Nurse (RN) E, stated LPN U notified him Resident #13 had thrown a plastic bowl, hitting Resident #23 on the head after an argument on [DATE]. The Administrator confirmed Resident #23 sustained a laceration and bruising during the altercation and confirmed the facility's investigation substantiated abuse because the altercation resulted in an injury for Resident #23. 2. Review of the medical records and facility investigation documentation revealed a resident to resident altercation occurred between Resident #1 and Resident #12 on [DATE]. The incident of resident to resident abuse resulted in actual HARM to Resident #11 who sustained a bruise and abrasion on her left jaw when Resident #12 hit her in the face. Review of the medical record revealed Resident #11 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Muscle Weakness, Difficulty Walking, and GAD. Review of an admission MDS assessment dated [DATE], revealed Resident #11 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. The resident wandered but had not exhibited other behaviors. Review of the Nursing Progress Notes for Resident #11 dated [DATE] at 5:03 PM, revealed .[Resident #11] noted to be walking the hallway at approximately 1:20 pm [PM] Nurse was in hallway and observed [Resident #11] walking by another elder [Resident #12] and as nurse turned she observed other elder [Resident #12] appear as if something had happened. Nurse immediately intervened and separated the resident's [residents]. Head to toe assessment complete. [Resident #11] noted to have a small scratch to her left cheek .[Resident #11] did not appear to have any fear, anxiety, nor was she tearful . Review of the skin assessment document for Resident #11 dated [DATE], revealed the resident had a small scratch on her left lower jaw. Review of the PSYCHOSOCIAL/BEHAVIOR care plan for Resident #11 dated [DATE], revealed .the resident was monitored for increased need for psychosocial support and psychosocial support provided . Review of the Social Services Progress Notes for Resident #11 dated [DATE] at 5:49 PM, revealed the resident did not display signs of or voice fear, anger, depression or anxiety. Review of the NP Notes for Resident #11 dated [DATE], revealed .On [DATE] patient [Resident #11] was ambulating in hall when another female resident [Resident #12] made contact with an open hand gesture and made contact with patients [Resident #11] lower jaw .Immediately after the occurrence staff noted a small area circular to ovoid [egg shape] in appearance to [Resident #11's] left jawline with tiny open area and minimal bleeding . The resident showed no behavioral changes. Review of the Psychiatric Evaluation for Resident #11 dated [DATE], revealed the resident was involved in a resident-to-resident altercation. Resident #11 was hit by another resident (Resident #12). The resident was alert and calm; was not tearful or crying during the evaluation. The resident denied anxiety, agitation, and feeling depressed. Review of the Social Services Progress Notes for Resident #11 dated [DATE] and [DATE], revealed the resident did not display signs of or voice fear, anger, depression, or anxiety. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed Resident #12 was admitted to the facility on [DATE] with diagnoses including Dementia with Behavioral Disturbance, Depression, and GAD. Resident #12 expired on [DATE]. Review of the comprehensive care plan for Resident #12 dated [DATE] and updated on [DATE], revealed . Behavioral Res [Resident] has a dx [diagnosis] of Depression, Impulsiveness, GAD, & [and] Dementia with behaviors and is at risk for experiencing behaviors, Pacing, Periods of restlessness, & Verbal aggression/Physical Aggression .Resident sometimes calms when she has her baby doll .Encourage and assist to sensory room as tolerated by resident when noted to have increased agitation .Administer and monitor the effectiveness and side effects of medications .Anticipate care needs and provide them before the resident becomes overly stressed .Intervene as needed to protect the rights and safety of others; approach in calm manner, divert attention, remove from situation and take to another location as needed .Invite and encourage activity programs consistent with resident's interests . Review of a quarterly MDS assessment dated [DATE], revealed Resident #12 had severe cognitive impairment. The resident exhibited physical and verbal aggression toward others, rejected care, and wandered. Continued review revealed a BIMS assessment was not completed due to Resident #12's severe cognitive impairment. Review of the Nursing Progress Notes for Resident #12 dated [DATE], revealed .[Resident #12] noted to be walking the hallway at approximately 1:20 pm [PM] Nurse was in hallway and observed [Resident #12] walking by another elder [Resident #11] and as nurse turned she observed other elder [Resident #12] appear as if something had happened. Nurse immediately intervened and separated the resident's [residents]. Head to toe assessment complete. No injury noted to this resident [Resident #12]. Later observed during assessments that this resident [Resident #12] had hit another female elder [Resident #11] in the face causing a small scratch to her left cheek. Review of the skin assessment document for Resident #12 dated [DATE], revealed the resident had no skin impairment. Review of Nursing Progress Notes for Resident #12 dated [DATE] at 4:25 PM, revealed the resident was placed on 1:1 supervision (1 staff assigned to Resident #12 for monitoring) for 24 hours immediately following the incident. The resident remained on 1:1 supervision until she was sent to the emergency room (ER) for a psychiatric evaluation on [DATE] at 4:00 PM. Review of Nursing Progress Notes for Resident #12 dated [DATE] at 6:32 PM, revealed the resident returned to the facility from the ER with 1:1 supervision to continue until the resident was evaluated by the Psychiatric NP. Review of the PSYCHOSOCIAL/BEHAVIOR care plan for Resident #12 dated [DATE] revealed the resident had increased monitoring and supervision with psychosocial support provided. Review of the Psychiatric Evaluation for Resident #12 dated [DATE] at 2:12 PM, revealed the resident had been involved in a .resident to resident altercation where [Resident #12] had hit another resident on the face causing a small scratch, this resident [Resident #12] noted to be agitated . Resident #12 was calm and cooperative during the evaluation. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress Notes for Resident #12 dated [DATE] at 3:47 PM, revealed 1:1 supervision continued for the resident.We continue to monitor her very closely for any mood or behavioral changes . Review of the medical record revealed Resident #12 remained in 1:1 monitoring until [DATE]. Resident #12 did not exhibit any further aggressive or hostile behaviors and 1:1 monitoring was discontinued on [DATE]. Review of the facility's investigation documentation dated [DATE] at 1:20 PM, revealed Resident #11 told RN G that Resident #12 .had swatted at her [Resident #11's] face making contact . The residents were immediately separated.[Resident #11] does have small scratch to left cheek . Continued review revealed . The allegation is verified as evidenced by small scratch on left side of [Resident #11's] face and witnessed by nurse. Resident #12 had a prior history of verbal aggression but had not had issues of physical aggression. Resident #12 was placed on 1:1 observation . Review of the witness statement by RN G dated [DATE], revealed Resident #11 told RN G that Resident #12 hit her and touched the left side of her face.upon observation [Resident #11] had small amount of blood where she had been scratched on face . During observation and interview on [DATE] at 3:35 PM, Resident #11 was observed seated in a recliner in her room visiting with her son. She was smiling and exhibited no behaviors. When asked if there had been any problems with other residents, Resident #11's son stated something had happened in the hall, but it had been a while, and it was just a misunderstanding. He stated there had been no further issues. During an interview on [DATE] at 2:54 PM, RN G stated Resident #12 walk by and slapped at Resident #11 from the back. Resident #12 had a scratch on her cheek. During a telephone interview on [DATE] at 9:55 AM, CNA D stated Resident #11 and Resident #12 were walking in the hall, when 1 of the residents, who she thought was Resident #11 said Resident #12 had hit her. CNA D stated Resident #11 had a .very tiny spot on her face . During an interview on [DATE] at 11:45 AM, the NP stated Resident #11 had a small circular bruise measuring approximately 1.75 centimeters (cm) x 0.75 cm .with a little abrasion . on her left jaw. The NP confirmed Resident #11's injury occurred during the resident-to-resident altercation on [DATE]. During an interview on [DATE] at 2:15 PM, the Administrator, in the presence of the DON and RN E, stated RN G notified him of a physical altercation between Resident #11 and Resident #12 on [DATE] at 1:20 PM. Resident #11 had told RN G that Resident #12 had swatted at her face making contact. The Administrator stated Resident #11 had a small scratch to the left side of her face. The Administrator stated video surveillance footage was reviewed and revealed Resident #12 .reached and made contact with [Resident #11] . Continued interview revealed the allegation was verified due to Resident #11 having a small scratch on the left side of her face. The Administrator stated .It was a willful act . The Administrator confirmed the altercation was substantiated as abuse because Resident #11 had an area on her face. Video footage was no longer available for surveyor review. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	3. Review of the medical records revealed a resident to resident altercation occurred between Resident #14 and Resident #15 on [DATE]. The incident of resident to resident abuse resulted in actual HARM to Resident #14 who sustained bruising to his/her left forearm when Resident #15 bit him/her on the arm. Review of the medical record revealed Resident #14 was admitted to the facility on [DATE] with diagnoses including Dementia, Muscle Weakness, Pain, and Depressive Disorder. Review of the admission MDS assessment dated [DATE], revealed Resident #14 scored a 7 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the Nurse's Progress Notes for Resident #14 dated [DATE], revealed Resident #15 entered Resident #14's room. When Resident #14 attempted to assist Resident #15 out of the room, Resident #15 grabbed Resident 14's left arm and bit the resident. Resident #14 was placed on every 15-minute checks for safety. Review of the Nurse's Progress Notes for Resident #14 dated [DATE], revealed the resident was assessed by the Nurse Practitioner (NP) and found significant bruising to the left forearm from the bite the resident received from Resident #15. Review of the comprehensive care plan for Resident #14 dated [DATE], revealed a new problem . Psychosocial Well-Being . Resident at risk for psychosocial related stress following resident to resident altercation .[interventions] .Discuss coping strategies with resident and/or family as needed .encourage family/friends to remain involved .Observe resident for the need for psychological/psychiatric services . Psychosocial support from staff .Social services to be available as needed . Review of the medical record revealed Resident #15 was admitted on [DATE] with diagnoses including Diabetes Type II, MDD, Transient Ischemic Attack (small strokes), and Chronic Pain. Review of the annual MDS assessment dated [DATE], revealed Resident #15 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. The MDS also revealed Resident #15 had no behaviors during the assessment period. Review of the Nurse's Notes for Resident #15 dated [DATE], revealed the resident entered another resident's room (Resident #14). When Resident #14 was trying to show Resident #15 the way out, Resident #15 grabbed Resident #14's left arm and bit it. Resident #15 was placed on 15 minutes checks and monitored for additional physical aggression towards the other residents. Review of the Nurse's Notes for Resident #15 dated [DATE], revealed the NP assessed the resident. The NP note revealed the resident had no recollection of the incident on [DATE]. Review of comprehensive care plan for Resident #15 dated [DATE], revealed Problem .Behavioral Resident demonstrates inappropriate behaviors including: physical aggression towards other residents .Approach .1 on 1 staff supervision .Assist resident to away from other residents as needed .Determine the cause for inappropriate behavior and refer to physician for intervention .Encourage participation in structured activities as appropriate .Monitor for Psychosocial disturbance related to 1:1 incident .Observe for triggers of inappropriate behavior and alter environment as needed .Observe for unmet needs such as for toileting, rest, food, fluids, companionship . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Greeneville	106 Holt Court Greeneville, TN 37743

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Police Report Incident documentation dated [DATE], revealed Officer .responded a Simple Assault .On arrival, I [officer] spoke to .[DON] . The DON stated Resident #14 and Resident #15 had gotten into an altercation where Resident #15 had bitten Resident #14 .no charges were being filed . During an interview on [DATE] at 9:30 AM the Administrator stated the bite from Resident #15 to Resident #14 was abuse and the resident was harmed during the altercation. During an interview on [DATE] at 11:40 AM the NP verified Resident #14 sustained a bite on the left forearm that resulted in significant bruising, and Resident #14 was harmed by Resident #15. 4. Review of the medical records and facility investigation documentation revealed a resident to resident altercation occurred between Resident #8 and Resident #1 on [DATE]. Review of the medical record revealed Resident #8 was admitted to the facility [DATE] with diagnoses including Multiple Sclerosis, Depression, Anxiety, Insomnia and Neuropathy. Review of an admission MDS assessment dated [DATE], revealed Resident #8 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. The resident had not exhibited behaviors toward others. Review of the Nursing Progress Notes for Resident #8 dated [DATE] at 7:45 AM, revealed the resident had been involved in a resident-to resident altercation with Resident #1. Resident #8 was sitting in front of the nurse's station when Resident #1 yelled out shut up to Resident #8.[Resident #8] was hit open handed on left side of face/ forehead . The residents were immediately separated. Head to toe assessments were performed for both residents with no injuries noted. Review of the comprehensive care plan for Resident #8 dated [DATE], revealed .Psychosocial Well-Being At risk for decline in psychosocial well being related to resident to resident altercation .Approach .Activities of choice .Encourage social engagement activities of resident choice .Increased psychosocial support as needed .Observe and report to physician any changes in mood, behavior, cognition, and level of functioning caused by situational stressor(s) .Observe for psychosocial changes .Reinforce appropriate expression of feelings . Review of Social Services Progress Notes for Resident #8 dated [DATE] and [DATE] at 6:41 PM, revealed the resident did not display signs of anxiety, depression, anger, or hostility. Review of Social Services Progress Notes for Resident #8 dated [DATE] at 5:24 PM, revealed the resident did not display signs of anxiety, depression, anger, or hostility. During an observation on [DATE] at 3:31 PM, Resident #8 was observed in the main dining room where he had been participating in an activity. The resident was talkative, stated everything was going good, and no behaviors were noted. During an observation on [DATE] at 7:53 AM, revealed Resident #8 was in the day room eating breakfast and watching television with no behaviors noted. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an observation and interview on [DATE] at 7:55 AM, Resident #1 was seated in a chair in the dining room on the secured unit, drinking coffee.When asked if he had had any problems with other residents he stated .no, not that I know [TRUNCATED]

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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** 27405 Based on facility policy review, medical record review, facility investigation review, personnel file review, and interview, the facility failed to protect a resident's rights to be free from misappropriation and/or exploitation when money totaling $600.00 was taken from 1 resident (Resident #34) of 8 sampled residents reviewed for misappropriation. The findings include: Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised on 10/17/2022, revealed .It is the organizations intention to prevent the occurrence of abuse, neglect and misappropriation of property .and to assure that all alleged violations of federal or state laws .are investigated and reported immediately . Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Functional Quadriplegia, Hypertension, Type 2 Diabetes Mellitus, and Heart Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #34 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact. Review of the facility investigation documentation dated 11/15/2022, revealed while the facility's Administrator was in Resident #34's room, the resident told the Administrator he needed help setting up a sting operation. The resident stated Certified Nursing Assistant (CNA) Z had taken money from him totaling $600.00 and he had a video of her doing so. The CNA was contacted by the facility on 11/15/2022 and was immediately placed on suspension. Continued review showed the video footage was no longer available for surveyor review. Review of the personnel file for CNA Z revealed the facility terminated CNA Z on 11/18/2022 for violation of company policy. Review of a State of Tennessee Licensure/ Certification report pulled 6/4/2024 revealed CNA Z's License Current Status as being Revoked. Review of a Resident lost, stolen, or damaged replacement form revealed a check was issued to Resident #34 in the amount of $600.00. During an interview on 6/5/2024 at 3:11 PM, the Administrator confirmed the facility substantiated the allegation of misappropriation on Resident #34. The Administrator stated the $600.00 was reimbursed to Resident #34. The Administrator further confirmed the facility failed to protect Resident #34 against misappropriation of property.

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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** 36003 Based on facility policy review, medical record review, review of facility investigation documentation, police report review, and interviews the facility failed to report allegations of abuse to the State Agency for 6 residents (Resident #1, #8, #5, #6, #7, and #36) and failed to report an allegation of misappropriation of property for 1 resident (Resident #34) of 37 residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised on 10/17/2022, revealed .It is the organizations intention to prevent the occurrence of abuse .and to assure that all alleged violations of federal or State laws which involved abuse .are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law .the Facility Administrator, or his or her designee, will conduct a reasonable investigation of each such alleged violation .The Facility Administrator is responsible for reporting all investigations' results to applicable State agencies .Abuse .the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .includes verbal abuse, sexual abuse, physical abuse, and mental abuse .Physical abuse .Includes, but is not limited to, hitting, slapping, pinching, kicking .or any similar touching of a resident that does not have an appropriate therapeutic purpose, and that is not reasonable related to the appropriate provision of ordered care and services .Allegation of Abuse .Means a report, complaint, grievance, statement, incident, or other facts that a reasonable person would understand to mean that abuse .is occurring, has occurred, or plausibly might have occurred .All alleged violations involving abuse .are reported immediately , but no later than 2 hours after the allegation is made .all allegations and incidents of abuse .will be reported 'immediately,' .Reporting Guidelines .Any abuse allegation must be reported to State within 2 hours from the time the allegation was received . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the 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, neglect, exploitation, injuries of unknown origin, and misappropriation of resident property, and to assure that all alleged violations of federal or State laws which involve abuse, neglect, exploitation, injuries of unknown origin and misappropriation of resident property are investigated, and reported immediately to the Facility Administrator, the State Survey Agency, and other appropriate State and local agencies in accordance with Federal and State law .All alleged violations involving abuse, neglect, exploitation, or mistreatment are reported immediately, but no later than 2 hours after the allegation is made .all allegations and incidents of abuse or neglect, as defined in this policy, will be reported immediately, .Prevention .Establishing a safe environment that supports, to the extent possible, a resident's safety .Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur .Investigation Guidelines .The Facility Administrator will investigate all allegation, reports, grievance, and incidents that potentially could constitute allegations of abuse .The Facility Administrator may delegate some or all of the investigation as appropriate, but the Facility Administrator retains the ultimate responsibility to oversee and complete the investigation, and to draw conclusions regarding the nature of the incident .Reporting Guidelines .Any abuse allegation must be reported to State within 2 hours from the time the allegation was received . 1.The facility failed to report an allegation of resident-to-resident abuse that occurred between Resident #1 and Resident #8 on 2/26/2024 to the State Survey Agency. Review of the medical record revealed Resident #1 (alleged perpetrator) was admitted to the facility on [DATE] with diagnoses including Right Femur Fracture, Metabolic Encephalopathy (condition in which brain function is disturbed due to different diseases or toxins in the body), Acute Respiratory Disease, Reduced Mobility, Vascular Dementia without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, and Anxiety. Review of an admission Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. The resident had not exhibited behaviors toward others. Review of the Nursing Progress Notes for Resident #1 dated 2/26/2024 at 8:55 AM, revealed Resident #1 had a resident-to-resident altercation with another male resident (Resident #8) that was sitting beside him in front of the nurse's station.Nursing reports [Resident #1] was just sitting in w/c [wheelchair] and all of sudden yelled out 'shut up' to [Resident #8] sitting beside him, then he [Resident #1] proceeded to swing open handed and hit .[Resident #8] . on left side of face/forehead . The residents were immediately separated. Head to toe assessment revealed neither Resident #1 nor Resident #8 had injuries. Review of the medical record revealed Resident #8 was admitted to the facility 1/21/2024 with diagnoses including Multiple Sclerosis, Depression, Anxiety, and Neuropathy. Review of an admission MDS assessment dated [DATE], revealed Resident #8 scored an 11 on the BIMS assessment which indicated the resident had moderate cognitive impairment. The resident had not exhibited behaviors toward others. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a police report dated 2/26/2024, revealed .On February 26th at approximately 0600 [6:00 AM], [Resident #1] smacked [Resident #8] unprovoked while at the nurses' station . Review of the Nursing Progress Notes for Resident #8 dated 2/26/2024 at 7:45 AM, revealed the resident had been involved in a resident-to resident altercation with another male resident [Resident #1]. Resident #8 was sitting in front of the nurse's station when another male resident [Resident #1] yelled out shut up to Resident #8. Resident #8 was hit open handed on left side of face/ forehead. The residents were immediately separated. Head to toe assessments were performed for both residents with no injuries noted. Review of the facility's event report documentation dated 2/26/2024 at 8:55 AM, revealed .Resident [#1] noted to have a resident to resident altercation with another male resident that was sitting beside him early am [morning] .in front of nurse's station .Nursing reports resident was just sitting in w/c and all of sudden yelled out shut up to resident sitting beside him, then he proceeded to swing open handed and hit other resident [Resident #8] on left side of face/forehead. Nursing immediately separated residents .Head to toe assessment was complete per nurse who reports no injury . There was no evidence to show the State Agency was notified of the resident-to-resident altercation. Review of the witness statement by LPN W dated 2/26/2024, revealed LPN W .heard commotion behind me when I turned around [Resident #1] was telling [Resident #8] to shut up and then he swung at [Resident #8] hitting him open handed in the face. At that point they both started swinging at each other just bumping hands . The residents were separated. Review of the witness statement by LPN U dated 2/26/2024, revealed LPN U .was at NSG [nursing] station [and] heard [Resident #1] yell out 'shut up' .reach over and hit [Resident #8] on left side of head/face . The residents were separated. During an interview on 6/3/2024 at 12:38 PM, the Director of Nursing (DON) stated the facility did not report the resident-to-resident altercation between Resident #1 and Resident #8 which occurred on 2/26/2024 to the State Agency. The DON stated the corporate office advised the facility to not report the allegation of abuse to the State Agency because there were no injuries to either resident. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2024 at 8:45 AM, with the DON, Registered Nurse (RN) E (DON at the time of the incident), and the Administrator, the Administrator stated he was made aware of the incident between Resident #1 and Resident #8 around 5:00 AM or 6:00 AM on the morning of the event (2/26/2024) by LPN W. The Administrator stated the incident was reported to Adult Protective Services (APS), the Ombudsman, and the Police Department. Continued interview revealed the incident was discussed with the facility's regional team and it was determined the incident did not meet the definition of abuse. RN E stated the video surveillance footage revealed Resident #1 and Resident #8 were sitting side by side in front of the Long-Term Care Unit nurse's station. Resident #8 was talking with a nurse.[Resident #1] told him [Resident #8] to shut up and [Resident #1] .hit [Resident #8] back handed on the side of [Resident #8's] head .There was contact . During further interview the Administrator stated .There was a willful intent but there was no physical harm, mental anguish, or pain . The Administrator stated based on the facility's interpretation of the changes in regulations related to reporting abuse in 10/2022, guidance by the corporate office and Tennessee Health Care Association (THCA), allegations of resident-to resident abuse were not reported to the State Agency unless there was physical harm, mental anguish, or pain. The Administrator stated the facility stopped reporting resident-to-resident altercations which did not have physical injury, mental anguish, or pain in 2024. The Administrator acknowledge the facility's process for reporting allegations of abuse had been inconsistent. The Administrator confirmed the allegation of resident-to-resident abuse for Residents #1 and #8 had not been reported to the State Agency. 45837 2. The facility failed to report an allegation of resident to resident abuse that occurred between Resident #5 and #6 on 4/11/2024 to the State Survey Agency. Review of the medical record revealed Resident #5 was admitted to the facility on [DATE] with diagnoses including Fracture of Left Femur, Generalized Anxiety Disorder (GAD), and Dementia. Review of a quarterly MDS assessment dated [DATE], revealed Resident #5 scored a 2 on the BIMS assessment, which indicated severe cognitive impairment, and exhibited inattention. The resident had physical behavioral symptoms noted. Review of the Nurse's Progress Notes for Resident #5 dated 4/11/2024, revealed the Assistant Director of Nursing (ADON) documented at approximately 5:35 PM, Resident #5 was in dining area propelling self in wheelchair. Resident #5 was yelling out sporadically and Resident #6 showed physical aggression towards Resident #5. Residents #5 and #6 were immediately separated and no injuries were noted. Review of the Nurse Practitioner (NP) Progress Notes for Resident #5 dated 4/12/2024, revealed Resident #5 who has profound and progressive Dementia resided on the secured and was in the common area last evening. Resident #5 was near Resident #6 and threw an empty tissue box toward him. Resident #6 who has profoundly cognitive impairment reacted by standing to his feet and attempting to pick Resident #5 up out of her wheelchair. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Dementia, Muscle Weakness and Depressive Disorders. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a quarterly MDS assessment dated [DATE], revealed Resident #6 scored an 8 on the BIMS assessment, which indicated moderate cognitive impairment. The resident had disorganized thinking and no behaviors. Review of a Police Department Incident Report dated 4/11/2024, revealed an officer arrived at 6:00 PM for a simple assault call. The ADON called to report Resident #6 had assaulted Resident #5. Resident #6 picked Resident #5 up out of her chair. Review of an APS report dated 4/11/2024, revealed a report was filed about the resident to resident altercation between Residents #5 and #6 at 6:54 PM. There was no evidence in the facility documentation a report was made to the state agency to notify of the resident to resident altercation. During an interview on 6/4/2024 at 4:09 PM, the ADON stated she provided care for Residents #5 and #6 at the time of the incident. She stated she was in the dining area when Resident #5 was in her wheelchair and propelled past Resident #6, and he suddenly grabbed her and picked her up out of her wheelchair. Staff notified police, NP, Resident #6's son and EMS (Emergency Medical Services), and obtained an order to send Resident #6 to the emergency room (ER) for acute behavioral disturbance. Further interview revealed no injuries were noted to Resident #5 or Resident #6. During an interview on 6/4/2024 at 5:30 PM, the Administrator stated he was notified about the incident between Residents #5 and Resident #6 on 4/11/2024 at about 5:45 PM. The Administrator stated the incident was not reportable to the state agency because there was no injury or psychosocial harm to either resident. The Administrator confirmed the incident was a willful act when Resident #6 got up, went to Resident #5 and picked her up out of a wheelchair. The Administrator stated .it was a resident-to-resident altercation, not abuse, because there was no injury . 3. The facility failed to report an allegation of resident to resident abuse that occurred between Resident #1 and #6 on 4/27/2024 to the State Survey Agency Review of the Nurse's Progress Notes for Resident #1 dated 4/27/2024 at 8:19 PM revealed .Notified by staff that at approximately 6:10 PM [Resident #1] was propelling in wheelchair by room [Resident #6's room] . [Resident #6] who was walking behind his wheelchair then hit him [Resident #1] open handed on the left side of his face .no injuries noted .will continue to monitor . Review of a Nurse's Progress Note for Resident #6 dated 4/27/2024 at 8:23 PM, revealed at approximately 6:10 PM Resident #6 was walking outside of his room behind Resident #1 in a wheelchair. Resident#6 suddenly hit Resident #1 across the left side of the face with an open hand and the residents were immediately separated. Resident #6 was placed on 1 on 1 observation. A NP order was received to send Resident #6 for a psychiatric evaluation, and notifications were made to the police, APS, Ombudsman, and the resident's son. Review of a witness statement dated 4/27/2024, revealed LPN BB documented Resident #6 hit Resident #1 open handed and from behind, in the face. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Police Department Incident Report dated 4/27/2024, revealed a Police Officer responded to a Simple Assault. Resident #6 stated that a friend had struck him and after talking with the facility staff, it was found that Resident #6 had struck Resident #1. Resident #6 admitted to the Police Officer he remembered striking Resident #1. Review of the facility's incident documentation revealed no evidence that a report was made to the state agency regarding the resident to resident altercation between Resident #1 and Resident #6. During a telephone interview on 6/5/2024 at 8:16 PM, CNA AA stated on 4/27/2024 at about 6:00 PM, Resident #1 was in a wheelchair at the door of Resident #6's room. The CNA stated Resident #6 came up behind Resident #1 and hit him open handed on the left side of the head around the ear and cheek. During an interview on 6/6/2024 at 8:45 AM, with the DON, RN E and the Administrator, the Administrator stated he was made aware of a resident-to-resident altercation on 4/27/2024 at 6:10 PM, and he came to the facility. The Administrator stated the residents were separated immediately and video evidence was reviewed as part of the investigation. The video evidence revealed that Resident #1 had waved as he passed #6's room, and Resident #6 made contact with Resident #1 from behind with an open-handed slap to side of head, and the staff saw it on camera. The Administrator reported the altercation to APS, Ombudsman, police, MD, and Psych NP, but did not report the resident-to-resident altercation to the state agency because .there was no injury, pain or psychosocial harm .I did not believe I should report it to the state .I did follow my policy . 27405 4. The facility failed to report an allegation of resident-to-resident abuse that occurred between Resident #7 and #36 on 3/2024 to the State Survey Agency. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE] with diagnoses including Abnormalities of Gait and Mobility, Anemia, and Adult Failure to Thrive. Review of the Nurse's Progress Notes for Resident #7 dated 3/20/2024, revealed during the lunch in the main dining area, Resident #7 was observed by staff punching Resident #36 in the shoulder. Review of a quarterly MDS assessment dated [DATE], revealed Resident #7 scored an 8 on the BIMS assessment which indicated moderate cognitive impairment. Review of the medical record revealed Resident #36 was admitted to the facility on [DATE] with diagnoses including Pneumonia, Need for Assistance with Personal Care, Dementia, and Heart Failure. Review of a quarterly MDS assessment dated [DATE], revealed Resident #36 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Review of the Nurse's Progress Notes for Resident #36 dated 3/20/2024, revealed during the lunch in the main dining area, Resident #6 was engaged in a verbal altercation with Resident #7 which led to Resident #7 punching Resident #36 in the left shoulder. No injuries were noted. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Police Department Incident Report dated 3/20/2024, revealed on 3/20/2024 at 12:58 PM, Police Officers responded to a simple assault between two residents. The document revealed Resident #7 and Resident #36 were at the lunch table when Resident #7 struck Resident #36. There were no injuries to either party. Review of a skin assessment for Resident #36 completed on 3/20/2024, revealed no injuries. Review of a Psychiatric NP note dated 3/20/2024, for Resident #36 revealed the resident was evaluated due to reports of an altercation with another resident. Resident #26 was noted in a scuffle but the details were unclear. During an interview on 6/5/2024 at 10:22 AM, the Speech Language Pathologist (SLP) stated she could hear arguing when the incident happened on 3/20/2024 and observed Resident #7 make contact with Resident #36. Continued interview revealed it was not a hard hit as neither resident had much upper body strength, but contact was made. During an interview on 6/5/2024 at 10:24 AM, CNA I stated she heard arguing on 3/20/2024 and observed Resident #7 hit Resident #36 in the arm. During an interview on 6/6/2024 at 8:44 AM, the Administrator confirmed physical contact occurred when Resident #7 struck Resident #36. Continued interview with the Administrator stated he had been made aware of the incident between Resident #7 and Resident #36 and had reported to APS, the Ombudsman, and the Police Department. Continued interview revealed the incident was discussed with the facility's regional team and it did not meet the definition of abuse because no physical harm, mental anguish, or pain was determined so the incident was not reported to the State Agency. 5. The facility failed to timely report an allegation of misappropriation of Resident #34's funds by a staff member to the State Survey Agency. Review of the medical record revealed Resident #34 was admitted to the facility on [DATE] with diagnoses including Functional Quadriplegia, Hypertension, Type 2 Diabetes Mellitus, and Heart Disease. Review of a quarterly MDS assessment dated [DATE], revealed Resident #34 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of a facility investigation dated 11/15/2022 revealed, while the facility Administrator was in Resident #34's room, the resident stated he needed help setting up a sting operation. The resident stated CNA Z had taken money from him totaling $600.00 and he had a video of her doing so. The facility investigation revealed the Staff Development Coordinator (SDC) who had been previously the residents floor nurse had knowledge of the incident prior to Resident #34 reporting to the Administrator. The CNA was contacted on 11/15/2022 and immediately placed on suspension. The video footage was no longer available for review. Review of the personnel file for CNA Z revealed the facility terminated CNA Z on 11/18/2022 for violation of company policy. Review of the personnel file for the SDC revealed the facility terminated the SDC on 11/23/2022 for violation of company policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445351	A. Building B. Wing	06/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Greeneville	106 Holt Court Greeneville, TN 37743

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	Review of a State of Tennessee Licensure/ Certification report pulled 6/4/2024 revealed CNA Z License Current Status as Revoked. During an interview on 6/5/2024 at 12:37 PM the SDC stated she was a floor nurse when first was approached by Resident #34 about the possibility of someone stealing from him. The SDC stated she did not remember an exact date but it was sometime around the end of 2021 or start of 2022 when the resident mentioned the theft to her. The SDC stated the resident was informed he should report it to the Administrator. The SDC stated Resident #34 told the SDC .he doesn't have any proof yet and wasn't going to make any accusations until he knew for sure . Continued interview revealed the SDC was approached again by the resident who declined reporting the theft until he had sufficient proof. Further interview confirmed the SDC failed to report the allegations of misappropriation (date(s) unknown) to the acting Administrator or to anyone else, until the allegations were brought to her attention by the current Administrator after 11/15/2022. During an interview on 6/5/2024 at 3:11 PM, the Administrator stated he was in Resident #34's room on 11/15/2022 when the resident showed him a video of CNA Z taking money out of his nightstand and placing in her pocket. Continued interview revealed the resident stated he had not authorized the CNA to retrieve money from his nightstand. The Administrator stated he immediately began investigation when the information was presented to him. The Administrator stated the SDC had knowledge of the alleged theft prior to 11/15/2022. Further interview revealed CNA Z and the SDC were terminated with legal charges brought against CNA Z by Resident #34. The facility substantiated the allegation of misappropriation of property and the $600.00 which was stolen, was reimbursed to Resident #34. Further interview confirmed the facility failed to report the misappropriation of property timely for Resident #34 since the SDC had knowledge (exact date unknown)of the alleged theft prior to 11/15/2022.