Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445363	A. Building B. Wing	01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Standing Stone Care and Rehab	410 W Crawford Avenue Monterey, TN 38574

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** 40606 Based on facility policy review, facility investigation documentation review, medical record review, observations, and interviews the facility failed to protect the residents' right to be free from physical abuse by another resident for 8 residents (Residents #5, #6, #7, #8, #10, #11, #14, and #15) of 14 residents reviewed for abuse. The findings include: Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised [DATE], revealed .organizations intention to prevent the occurrence of abuse .all alleged Abuse, Neglect, exploitation, injuries of unknown origin, and Misappropriation of resident property is investigated .are reported immediately . Abuse is the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish . 1. On [DATE], Resident #6 placed hands on Resident #5's chest and pushed Resident #5 backward in wheelchair. Review of the facility investigation dated [DATE], revealed an altercation between Resident #5 and Resident #6 had occurred. A Certified Nursing Assistant (CNA) overheard Residents #5 and #6 talking with a raised tone at the entrance of the residents' room and walked toward the room. The CNA stated she heard Resident #6 saying to Resident #5 .you cannot come in here; this is my room . Continued review revealed the CNA attempted to redirect Resident #6 and observed Resident #6 place both hands on Resident #5's chest and pushed the resident backwards in the wheelchair. Both residents were separated and assessed, no injuries were noted to either resident. Resident #6 was placed on 1 to 1 observation until transfer to Geriatric-Psychiatric (Geri-psych or Geropsych) for evaluation and treatment. Further review revealed . Resident to resident altercation was witnessed via [by way of] staff member and verified as having occurred . Resident #6 did not return to the facility after the hospitalization . Review of the medical record revealed Resident #5 was admitted to the facility on [DATE], with diagnoses including Dementia with Agitation, Foot Drop of Left Foot, Acquired Absence of Right Leg above Knee, and Peripheral Vascular Disease. (continued on next page)

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

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #5 scored a 10 on the Brief Interview for Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Review of a comprehensive care plan for Resident #5 dated [DATE], revealed .Resident involved in resident-to-resident altercation .Assist resident to move away from other residents as needed .Observe for triggers of inappropriate behaviors and alter environment as needed .Observe for unmet needs . Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Dementia, Psychotic Disturbance, Mood Disturbance, and Anxiety, Cerebral Infarction (Stroke), and Urinary Tract Infection. Review of the admission MDS assessment dated [DATE], revealed Resident #6 scored a 5 on the BIMS assessment which indicated severe cognitive impairment. Review of a comprehensive care plan for Resident #6 dated [DATE], revealed .Resident demonstrated inappropriate behaviors including .Resident-to-Resident altercation .Residents behaviors will not result in disruption of others environment .Observe for triggers of inappropriate behaviors and alter environment as needed .Observe for unmet needs . Multiple observations were made of Resident #5 at various times during the complaint investigation on [DATE]-[DATE], the resident participated in group activities in the secure unit. Resident #5 did not display disruptive or aggressive behavior during the observations. During an interview on [DATE] at 3:40 PM, Licensed Practical Nurse (LPN) B stated she could not recall details regarding Resident #6, however she stated Resident #5 did not display behaviors and was not aggressive towards other residents or staff during the times she had cared for Resident #5. During an interview on [DATE] at 9:30 AM, the former Administrator confirmed the physical altercation between Residents #5 and #6 was witnessed by staff, who had to intervene and separate the residents. 2. On [DATE], Resident #8 struck Resident #7 in the back resulting in a fall. Review of facility investigation documentation titled, Timeline and Summary of events, dated [DATE], revealed the Unit Manager/LPN M was notified of a physical altercation between Resident #7 and Resident #8 on the secure unit. Continued review revealed Resident #8 struck Resident #7 in the back, causing Resident #7 to fall in the dayroom of the secure unit. Resident #7 was not injured from the fall. The investigation documented Resident #7 stated Resident #8 had removed Resident 7's eyeglasses .Resident #8 does not wear corrective lenses . Witness statements corroborated Resident #8 does not wear eyeglasses and believed Resident #7 had taken his eyeglasses. The residents were separated immediately and placed on 1 to 1 supervision by the direct care staff until Resident #8 was transferred to a Geri-psych. hospital for evaluation and treatment. Resident #8 did not return to the facility after the hospitalalization. Review of the medical record revealed Resident #7 was admitted to the facility on [DATE], with diagnoses including Dementia with Behavioral Disturbance, Depression, and Insomnia. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed Resident #7 scored a 9 on the BIMS assessment which indicated moderate cognitive impairment. Review of the comprehensive care plan for Resident #7 dated [DATE], revealed .This resident was involved in resident-to-resident altercation: Physical . with interventions in place. Review of the medical record revealed Resident #8 was admitted to the facility on [DATE] with diagnoses including Restlessness and Agitation, Depression, Dementia, Psychotic Disturbance, Mood Disturbance, Anxiety, and Insomnia. Resident #8 was discharged from the facility on [DATE] to a local hospital for evaluation and treatment in a Geri-psychiatric Services unit and did not return to the facility. Review of the quarterly MDS assessment dated [DATE], revealed Resident #8 was rarely/never understood, the BIMS assessment could not be completed. Review of the comprehensive care plan for Resident #8 dated [DATE], revealed .This resident was involved in resident-to-resident altercation: Physical . with interventions in place. During an interview on [DATE] at 9:30 AM, the former Administrator confirmed the physical altercation was substantiated upon the facility's investigation between Resident #7 and Resident #8 and Resident #8 had struck Resident #7 resulting in a fall on [DATE]. 3. On [DATE], Resident #11 was observed striking Resident #10. Review of a facility reported investigation of a resident to resident altercation between Resident #11 and Resident #10 dated [DATE], revealed Resident #10 was heard yelling, a CNA entered the room and observed Resident #11 standing beside of Resident #10 striking the resident. The residents were immediately separated and assessed for injury with none noted. Neither of the residents were able to state what had occurred. Resident #11 was placed with 1 on 1 supervision until the resident was transferred to the hospital for inpatient Gero psych. evaluation on [DATE]. Resident #11 returned to the facility on [DATE]. Medical record review revealed Resident #10 admitted to the facility on [DATE], with diagnoses including Pneumonia, Diabetes Mellitus, Surgical Aftercare on the Digestive System, Dementia, Psychotic Disturbance, and Unspecified Intellectual Disabilities. Review of the admission MDS assessment dated [DATE], revealed Resident #10 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan dated [DATE], revealed Resident #10 had a behavioral care plan with interventions and monitoring implemented for mood state. During an interview on [DATE] at 2:45 PM, LPN L stated Resident #10 passed away in the facility on [DATE] under hospice services. Medical record review revealed Resident #11 admitted to the facility on [DATE], with diagnoses including Dementia, Anxiety, and Muscle Weakness. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly MDS assessment dated [DATE], revealed Resident #11 scored a 15 on the BIMS assessment which indicated the resident was cognitively intact. Review of the comprehensive care plan dated [DATE], revealed Resident #11, had a behavioral care plan with interventions and monitoring implemented for medications for the diagnoses of Depression, Anxiety, and Insomnia. During an observation on [DATE] at 3:00 PM, revealed Resident #11 returned to her room with assistance by staff from an activity and no behaviors were noted. During an interview with CNA A on [DATE] at 3:05 PM, revealed Resident #11 was able to make her needs known and had not exhibited any behaviors toward other residents. During an observation on [DATE] at 2:40 PM, revealed Resident #11 interacted with other residents in the hallway, was calm, and no behaviors were exhibited. During an interview on [DATE] at 2:40 PM, Resident #11 denied an altercations with other residents. During an interview on [DATE] at 2:45 PM, LPN L stated Resident #11 had not exhibited any behaviors before the altercation or after returning from the hospital. During an interview on [DATE] at 8:15 AM, the former Administrator and current Administrator stated the physical altercations between Resident #10 and Resident #11were witnessed by facility staff and the facility's investigation was substantiated. The CNA and LPN that witnessed the altercation between Resident #10 and #11 on [DATE] were no longer employed by the facility and were unable to be reached by phone. 4. On [DATE], Resident #14 was observed by staff seated in the floor with Resident #15 yelling at him to get up so he could hit him again. Resident #14 was observed with redness to his chest and back of head. Review of a facility investigation of a resident to resident altercation dated [DATE], revealed LPN N was standing in the hallway when she heard a loud smack and something heavy hit the floor. LPN N entered the room and observed Resident #14 seated on the floor with Resident #15 standing beside of Resident #14 yelling for him to get up so he could hit him, again. The residents were separated and assessed for injury. Resident #14 was noted to have redness to the chest and back of head. Residents #14 and #15 were transferred to the hospital for evaluation. Resident #14 returned to the facility and Resident #15 was transferred to an inpatient Gero-psych. facility for evaluation. Medical record review revealed Resident #14 was admitted to the facility on [DATE], with diagnoses including Dementia, Mood Disorder, Delusional Disorder, and Anxiety. Review of the medical record revealed Resident #14 was deceased . Review of the comprehensive care plan dated [DATE], revealed Resident #14 had a behavioral care plan dated [DATE], with the intervention of monitoring for adverse effects from the incident. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medical record review revealed Resident #15 was admitted to the facility on [DATE], with diagnoses including Dementia, Hydrocephalus (buildup of fluid deep in the brain), Aftercare following surgery on the Nervous System, history of Transient Ischemic Attack, and Agitation. Review of the admission MDS assessment dated [DATE], revealed Resident #15 scored a 3 on the BIMS assessment which indicated severe cognitive impairment. Review of the comprehensive care plan dated [DATE] and revised [DATE], revealed Resident #15 had a behavioral care plan which included 1 on 1 supervision and a hospitalization for evaluation of behaviors. During an observation on [DATE] at 4:00 PM and [DATE] at 8:25 AM, revealed Resident #15 was seated in a reclining wheelchair in the living area with other residents. He appeared calm with no behaviors or distress noted. During an interview on [DATE] at 9:45 AM, LPN B stated Residents #14 and #15 were roommates on the secure unit at the time of the altercation on [DATE]. LPN B stated both residents were ambulatory, had a diagnosis of Dementia and were confused. Continued interview revealed neither resident had exhibited aggressive behaviors toward others prior to the altercation or after Resident #15 returned from the hospital. During an interview on [DATE] at 8:15 AM, the former Administrator and current Administrator stated Resident #15 reported to the nurse he had hit Resident #14 and if he would stand up, he would hit him again. Continued interviews confirmed the physical altercations between Resident #14 and #15 were substantiated following the facility's investigations. 35460 Review of a facility reported investigation of a resident to resident altercation between Resident #11 and Resident #10 dated [DATE], revealed Resident #10 was heard yelling, a Certified Nurse Assistant (CNA) entered the room and saw Resident #11 standing beside of Resident #10 and was striking at her. The residents were immediately separated and assessed for injury with none noted. Neither of the residents were able to state what had occurred. The Licensed Practical Nurse (LPN) notified the physician, families, and administration. The state and local agencies were notified timely. Resident #11 was placed with 1:1 supervision until she was transferred to the hospital for evaluation. The resident was transferred to inpatient Gero psych on [DATE]. The investigation included witness statements, resident interviews and/or skin assessments (BIMS assessment less than 8) with no concerns identified. All staff received re-education on Abuse. The resident returned to the facility on [DATE]. Medical record review revealed Resident #10 admitted on [DATE], with diagnoses including Pneumonia, Diabetes Mellitus, Surgical Aftercare on the Digestive System, Dementia, Psychotic Disturbance, and Unspecified Intellectual Disabilities. Review of the admission MDS dated [DATE], revealed Resident #10 scored a 5 on the BIMS assessment which indicated the resident had severe cognitive impairment. Review of the comprehensive care plan dated [DATE], revealed Resident #10 had a behavioral care plan with interventions and monitoring implemented for mood state. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN L on [DATE] at 2:45 PM, revealed Resident #10 passed away in the facility on [DATE]. Continued interview revealed the resident was on hospice services. The CNA and LPN that witnessed the altercation between Resident #10 and #11 were no longer employed by the facility and were unable to be reached by phone. Medical record review revealed Resident #11 admitted on [DATE], with diagnoses including Unspecified Dementia, Anxiety, and Muscle Weakness. Review of the quarterly MDS dated [DATE], revealed Resident #11 scored a 15 on the BIMS assessment which indicated she was cognitively intact. Review of the comprehensive care plan dated [DATE], revealed Resident #11, had a behavioral care plan with interventions and monitoring implemented for medications for the diagnoses of Depression, Anxiety, and Insomnia. Observation on [DATE] at 3:00 PM, revealed Resident #11 returned to her room with assistance from activities and was assisted to her bathroom. During an interview with CNA A on [DATE] at 3:05 PM, revealed Resident #11 was able to make her needs known and was both continent and incontinent at times. Continued interview revealed the CNA was unaware of any behaviors the resident had toward other residents. Observation on [DATE] at 2:40 PM, revealed Resident #11 interacted with other residents in the hallway, was calm, and no behaviors were noted. During an interview on [DATE] at 2:40 PM, Resident #11 denied recall of an altercation with other residents and reported no concerns with staff. During an interview with LPN L on [DATE] at 2:45 PM, revealed Resident #11 was alert and oriented. Continued interview revealed Resident #11 had not had any behaviors before the altercation or after returning from the hospital with medication changes. Review of a facility investigation of a resident to resident altercation dated [DATE], revealed LPN N was standing in the hallway when she heard a loud smack and then and heard something heavy hit the floor. Resident #14 was seated on the floor and Resident #15 was standing beside of him yelling for him (Resident #14) to get up so he could hit him again. The residents were separated and assessed for injury. Resident #14 was noted to have redness to his chest and back of head. The nurse notified the physician, families, and administration. Both residents were transferred to the hospital for evaluation. Resident #14 returned to the facility and Resident #15 was sent to inpatient Gero-psych. The state and local agencies were notified timely. The investigation included witness statements, resident interviews and/or skin assessments (BIMS assessment less than 8) with no concerns identified. All staff received re-education on Abuse. Medical record review revealed Resident #14 was admitted on [DATE], with diagnoses including Dementia, Mood Disorder, Delusional Disorder, and Anxiety. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the comprehensive care plan dated [DATE], revealed Resident #14 had a behavioral care plan dated [DATE], with the intervention of monitoring for adverse effects from the incident. Medical record review revealed Resident #15 was admitted on [DATE], with diagnoses including Dementia, Hydrocephalus (buildup of fluid deep in the brain), Aftercare following surgery on the Nervous System, history of Transient Ischemic Attack, and Agitation. Review of the admission MDS dated [DATE], revealed Resident #15 scored 3 on the BIMS assessment which indicated severe cognitive impairment. Review of the comprehensive care plan dated [DATE], revealed Resident #15 had a behavioral care plan dated [DATE] which included 1:1 supervision and hospitalization for evaluation of behaviors. Resident #14 was deceased . Observation on [DATE] at 4:00 PM, revealed Resident #15 was seated in a reclining wheelchair in the living area with other residents. He appeared calm with no distress noted. Observation on [DATE] at 8:25 AM, revealed Resident #15 was seated in the living area being assisted with breakfast. No behaviors noted. During an interview on [DATE] at 9:45 AM, with LPN B revealed Residents #14 and #15 were roommates on the secure unit at the time of the altercation, both residents were ambulatory, and had Dementia. Continued interview revealed neither resident had exhibited aggressive behaviors toward others prior to the altercation or after Resident #15 returned from the hospital. During an interview on [DATE] at 10:15 AM, with CNA D revealed Resident #14 and Resident #15 had never exhibited behaviors toward each other or others. Continued interview confirmed she was unaware of any other altercations for Resident #14 or Resident #15. During an interview on [DATE] at 8:15 AM, with the former Administrator and current administrator confirmed the physical altercations between Resident #10 and Resident #11, and the physical altercation between Resident #14 and #15 were substantiated following the investigations. The altercation between Resident #10 and Resident #11 was witnessed by staff. Resident #15 reported to the nurse he had hit Resident #14 and if he would stand up, he would hit him again.

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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** 30647 Based on facility policy review, medical record review, facility investigation review, and interview, the facility's direct care staff failed to immediately report allegations of staff on resident abuse which resulted in a delay of reporting abuse to the State Designated Authority for 1 resident (Resident #3) of 14 residents reviewed for abuse. The facility was cited at F-609 at a scope and severity of D as past noncompliance. Noncompliance began on 5/13/2024 and ended on 5/21/2024. The facility is not required to submit a Plan of Correction for F-609. The findings include: Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, dated 9/15/2023, revealed .Every Stakeholder shall immediately report any allegations of abuse .All such persons are encouraged to follow these reporting guidelines when they have reason to believe, that abuse, neglect, exploitation is occurring, has occurred, or plausibly may have occurred .Any abuse allegation must be reported to State within 2 hours from the time the allegation was received .Any allegation of neglect, exploitation, mistreatment or misappropriation of resident property must be reported to the State Regulatory Agency within 24 hours . Review of medical records revealed Resident #3 was admitted to the facility on [DATE], with diagnoses including Malignant Neoplasm of the Right Upper Lobe Lung, Secondary Malignant Neoplasm of Lymph Nodes of the Head, Face and Neck, Secondary Malignant Neoplasm of Bone, Addison's Disease, Anxiety Disorder, Depression, Restless and Agitation, and Chronic Obstructive Pulmonary Disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 12 on the Brief Interview of Mental Status (BIMS) assessment which indicated moderate cognitive impairment. Resident #3 required assistance of one or two persons for activities of daily living (ADLS). (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 investigation dated 5/14/2024, revealed on 5/11/2024, between 10:30 PM-11:30 PM, Resident #3 reported allegations to Housekeeper (HK) A that the Environmental Services Supervisor (EVS) had made sexually explicit statements/sexual advances and a proposition to engage in sexual intercourse with the resident. Continued review of the timeline revealed . [HK A] attempted to change the subject and left the facility at the end of her shift without escalating or reporting any concerns [allegations] . Continued review revealed on 5/12/2024 at approximately 4:30 AM (approximately 6-7 hours after the initial allegation was reported to HK A) Resident #3 reported to Registered Nurse (RN) X vague, non-specific concerns related to being fearful of the EVS. RN X advised Resident #3 the Staff Development Coordinator (SDC) would speak to her about concerns on arrival to the facility at approximately 5:30 AM that morning (2 hours after the allegation was made). RN X did not report Resident #3's safety concerns to the Director of Nursing (DON), Administrator, or the abuse coordinator until 7:16 AM (2 hours and 46 minutes after the resident reported the allegation to her). Further review of the facility investigation revealed the SDC interviewed Resident #3 on 5/12/2024 at approximately 5:30 AM. During the SDC interview, Resident #3 informed the SDC of her concerns for HK A's safety and reported allegations the EVS had previously made sexual advances towards HK A which made her fearful of the EVS. Resident #3 did not report the allegation the EVS had made sexual comments or sexual propositions towards her at the time of the 1st interview on 5/12/2024 at 5:30 AM but did state she was fearful of the EVS. The SDC did not report Resident #3's concerns of being fearful to the DON until 7:26 AM. Continued review of the facility timeline and witness statements revealed on 5/13/2024 around 10:00 AM, Resident #3 spoke with the facility's medical director and alleged the EVS had propositioned her for sex. The Physician reported the allegations to the SDC, the attending hospice physician, and the facility's DON. Continued review revealed on 5/13/2024 at 1:37 PM, the DON re-interviewed Resident #3 who stated she felt sexually harassed by the EVS. The DON reported the allegations to the facility's corporate officials, the administrator, local police, the state ombudsman office, and to the State Agency (SA) on 5/13/2024 at 1:47 PM (over 48 hours after the initial allegations were made by Resident #3 to HK A). During an interview on 1/14/2025 at 10:20 AM, the former Administrator confirmed all staff were required to report abuse allegations immediately, through the chain of command, to the Administrator or Designee as soon as they were identified. The Administrator confirmed HK A failed to follow the facility's abuse policy on 5/11/2024 regarding Resident #3's allegations, which led to a delay in the facility leadership being made aware and the reporting of the allegation to the state designated authority within the 2 hour time frame. During an interview on 1/14/2025 at 11:05 AM, HK A stated on 5/11/2024 Resident #3 reported to her the EVS had propositioned Resident #3 for sex. HK A reported Resident #3 made several odd statements that morning (leading HK A to believe Resident #3 was confused) prior to the allegations about the EVS and confirmed she did not report Resident #3's allegations. HK A stated RN X who was working at the time of the allegation, entered the resident's room a few moments after she had exited and assumed Resident #3 would repeat the allegations to the nurse. HK A confirmed the allegations by Resident #3 were reported to her near the end of her shift on 5/11/2024 between 10:00 PM and 11:00 PM and she had not informed the facility of the allegations until after she was questioned by the SDC on the morning of 5/12/2024 (1 day after the allegations were made). (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 1/14/2025 at 11:40 AM, the SDC stated she interviewed Resident #3 on the morning of 5/12/2024 around 5:30 AM after she arrived to work. The SDC stated at the time she initially interviewed Resident #3, she was not aware of the allegations of the sexual comments and sexual proposition by the EVS which was reported to HK A. The SDC stated RN X had informed her Resident #3 had reported concerns for her safety related to the EVS but was not given any specific details related to those concerns. The SDC stated initially Resident #3 made allegations she was fearful of the EVS because the EVS had made sexual advances towards HK A and she feared for HK A's safety. The SDC reported she informed the DON of the allegations and the DON assumed supervision of the investigation, which later revealed the additional allegations of sexual comments and proposition by the EVS to Resident #3 which was reported to HK A on 5/11/2024. The SDC stated she obtained written statements from all involved parties related to those allegations, which clarified the allegations and prompted the referral to the local police and the state agency for investigation. The allegations were reported to the state agency 2 days after Resident #3 made the initial report to HK A. The facility was cited as past non-compliance at F-609. Surveyors verified and validated the corrective action plan on site. The facility implemented the following corrective actions which were validated onsite by the surveyor on 1/14/2025 as follows: 1. On 5/13/2024 when the facility became aware of the full nature of the allegations the alleged perpetrator was immediately suspended. The facility conducted an ad hoc QA of the allegations and launched a full investigation which included interviews of all involved personnel and Resident #3. 2. The facility identified by investigative interviews conducted on 5/13/2024 HK had failed to report allegations of abuse immediately to facility administration and suspended HK pending outcome of the investigation as well. The facility suspended RN X for failure to launch an initial investigation immediately when Resident #3 informed her she feared the EVS. 3. The facility assessed all residents for potential impact of the allegations on 5/13/2024 and identified no other potential victims. Additionally, the facility interviewed multiple female staff as related to EVS with no negative findings. 4. The facility notified all authorities as required by law of the allegations once their true nature was identified within two hours of becoming aware of them on the afternoon of 5/13/2024. 5. The facility also performed skin assessments of all cognitively impaired elders with BIMS less than 8 on 5/13/2024 with no negative findings. 6. Resident #3 was examined by the hospice physician on 5/13/2024 who determined no signs of abuse were present, noted inconsistencies in Resident #3's allegations and mental status,and determined there was no evidence Resident #3 was abused as alleged and reported this to the facility IDT. The hospice physician's findings were conveyed to the facility medical director who also examined Resident #3 and concurred. Resident #3 was placed on increased monitoring as a precaution and the care plan was adjusted to reflect 2 persons in the room at all times and no male caretakers on 5/13/2024. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2025
NAME OF PROVIDER OR SUPPLIER: Standing Stone Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 410 W Crawford Avenue Monterey, TN 38574	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7. The family was contacted on 5/13/2024 for initial discussions related to the incident and additional follow up calls with the responsible party were completed on 5/15/2024 at the conclusion of the facility internal investigation, in which the facility findings and interventions put in place in response to the allegations were reviewed with the responsible party. 8. Resident #3 was examined by the Psychiatric Nurse Practitioner on 5/14/2024 with no new orders issued and no signs of mental duress present in Resident #3. The NP concurred with findings of both the hospice physician and medical director and changes to the care plan already in place. The facility also provided education to the resident council on escalation of abuse allegations on 5/14/2024. The resident council had no voiced concerns with EVS or abuse allegations to report to the facility. 9. The facility implemented a performance improvement plan (PIP) related to timely reporting of all potential abuse allegations to administration and the facility abuse prohibition policy on 5/13/2024, after consultation with Corporate officials was completed. Additional QA of the incident was performed on 5/14/2024, and root cause analysis of the incident was completed. All staff were required to be re-educated on the abuse policy and timely reporting requirements. Staff education began on 5/13/2024 and was completed on 5/21/2024. 10. The facility placed the incident on the Quality Assurance agenda for the following month after additional Quality Assurance Reviews of the incident were conducted on 5/15/2024. Follow up QA review of all interventions was performed on 5/21/2024 to ensure staff education was completed as directed. The facility also performed additional QA review of the incident and monitoring of the PIP on 6/5/2024 and again 6/10/2024. The facility continued to perform Quality Assurance Review of the incident through July 2024 with no further negative findings and no other instances of late abuse reporting detected. 11. EVS was terminated upon conclusion of the facility investigation on 5/15/2024. On 1/14/2025 the surveyor validated the corrective actions onsite by interview of 8 staff members all of whom were knowledgeable of the abuse prohibition and reporting requirements policy as well as internal mechanisms for reporting concerns with leadership by the corporate hot line. Interviews with the SDC and HK also confirmed they were suspended as reported and both completed re-education in relation to the incident and timely abuse reporting. RN X was no longer employed at the facility. Review of her personnel file showed RN X did complete training as required and was reinstated. On 1/14/2025 the surveyor reviewed additional resident council minutes from 7/2024 to 12/2024 showed no concerns with abuse or neglect at the facility. Review of complaint logs for the same period showed no other allegations of staff on resident sexual abuse. On 1/14/2025 the surveyor reviewed the facility corrective action records which were maintained in a binder specific to the complaint. Review of staff logs showed all staff members completed mandatory re-training by the dates specified as reported. On 1/14/2025 the surveyor completed reviews of personnel files for all staff members involved in the incident and verified retraining, corrective discipline and terminations as reported by the facility. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 the surveyor reviewed the law enforcement initial report and unredacted investigation notes provided by local police as related to the incident. On 1/14/2025 the surveyor completed review of the facility root cause analysis and PIP which corroborated data in the education materials used to re-educate staff in relation to the facility's self-identified noncompliance and corrective actions.