STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445393	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Signature Healthcare of Monteagle Rehab & Wellness	26 Second Street Monteagle, TN 37356

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 49786

Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to protect the residents' right to be free from physical abuse by another resident for 2 residents (Resident #6 and Resident #74) of 26 residents reviewed for abuse. The facility's failure to prevent resident to resident altercations resulted in actual harm for Resident #6. On 6/27/2024, Resident #283 struck Resident #6 with a water pitcher causing a laceration and bruising to the left eye on 12/15/2023 and Resident #74 when Resident #31 struck resident #74 with a walker causing a small cut to Resident #74's right earlobe and a skin tear to the resident's left hand, which resulted in actual HARM to Residents #6 and #74.

The findings include:

Review of the facility policy titled, Abuse, Neglect and Misappropriation of Property, revised 4/14/2022, 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 .

Review of the medical record revealed Resident #283 was admitted to the facility on [DATE] with diagnoses including Schizoaffective Disorder, Bipolar Type, Cognitive Communication Deficit, Unspecified Psychosis, Mood Disorder, and Alzheimer's.

Review of a comprehensive care plan for Resident #283 initiated 4/28/2022, revealed .Behavioral .at risk and/or active behavior problems .Physically Aggressive Verbally Aggressive .cursing, hitting and screaming . related to being easily agitated and difficult to redirect .staff will .Provide non-confrontational environment . Anticipate care needs .provide them before the resident becomes overly stressed .Allow resident adequate time to verbalize his feelings .praise him when he verbalizes them in a calm tone .Intervene as needed to protect the rights and safety of others; approach in calm manner, divert attention, remove from situation .take to another location as needed .report changes in behavioral health status to MD [medical doctor] .

Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #283 scored a 7 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident received antipsychotic and antianxiety medications during the assessment period.

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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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NAME OF PROVIDER OR SUPPLIER: Signature Healthcare of Monteagle Rehab & Wellness		STREET ADDRESS, CITY, STATE, ZIP CODE: 26 Second Street Monteagle, TN 37356	

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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 Behavioral Progress Notes for Resident #283 dated 11/9/2023, revealed . Depakote [medication used to stabilize mood] 250 milligrams [mg] TID [three times a day] .Klonopin [medication used to treat anxiety] 1 mg TID .Geodon [medication used to treat Bipolar Disorder] 40mg q [every] AM [morning] and 40mg q PM [night] .judgement poor .insight poor .continue current psych treatment . Review of the Nurse's Progress Notes for Resident #283 dated 11/15/2023, revealed . impatient with poor impulse control and verbal outbursts are common . Review of the comprehensive care plan for Resident #283 revised 12/15/2023, revealed the resident was involved in a resident to resident altercation. The interventions included .Separate resident immediately to reduce interactions with other resident's [residents] when he is agitated .one on one prn [as needed] .social services as needed . Review of the Social Work Notes for Resident #283 dated 12/15/2023, revealed .SSD [Social Service Director] was notified by DON [Director of Nursing] that a resident to resident [altercation] took place . [Resident #283] .struck .[Resident #6] .in the dining room with a water pitcher .[Resident #283] was sorry for his actions .[Resident #6] .was making inappropriate gestures .order from NP [Nurse Practitioner] to refer [Resident #283] to in-patient psych [psychiatric] related to resident to resident [altercation] . Review of the Nurse's Notes for Resident #283 dated 12/15/2023, revealed .resident [Resident #283] stated to the nurse .[Resident #6] .flipped me off so I hit him with my pink water pitcher .' Review of the facility investigation dated 12/15/2023, revealed a resident-to-resident altercation between Resident #283 and Resident #6 had occurred. A staff nurse was assisting a resident to the dining room. When the staff nurse entered the dining room a resident at the facility informed the nurse Resident #283 hit Resident #6 with a water pitcher. Resident #283 and Resident #6 were immediately separated. Resident #283 had a history of outbursts and aggressive behavior. Resident #283 was placed on 1:1 supervision until the resident was admitted to an inpatient psychiatric facility (admitted to an inpatient psychiatric facility on 12/15/2023 and did not return to the facility). Resident #6 sustained a small laceration/bruise above his left eye. No changes in Resident #6's behavior were observed. Review of the medical record revealed Resident #6 was admitted to the facility on [DATE], with diagnoses including Dementia, Major Depression, Anxiety, and Schizoaffective Disorder, Bipolar Type. Review of a comprehensive care plan for Resident #6 initiated 3/2/2018 and revised 12/15/2023, revealed . Behavioral .at risk for behaviors identified as verbal aggression, declining care, being short tempered, placing self on floor .staff will .Anticipate care needs and provide them before I become stressed .Monitor behavior to determine underlying cause . Consider location, time of day, persons involved .Provide non-confrontational environment .Refer to Psych NP as needed .Refer to Social Services as needed .Report to Physician any changes in behavioral status . Review of the Behavioral Progress Notes for Resident #6 dated 11/23/2023, revealed . thought process impaired, memory impaired, judgement poor .insight poor .Depakote 500 mg in the morning Remeron [medication used to treat depression] 7.5 mg at bedtime .maintain stabilization . (continued on next page)

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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 a quarterly MDS assessment dated [DATE], revealed Resident #6 was unable to complete the BIMS assessment, the resident was rarely/never understood, which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident did not receive antipsychotic medications during the assessment period. Review of a comprehensive care plan for Resident #6 revised 12/15/2023, revealed the resident was involved in a Resident-to-resident altercation. The interventions included .Care for abrasion to left eye, per order .Evaluate and monitor for pain and distress .Interview and monitor resident for psychosocial wellbeing . Review of the Nurse's Notes for Resident #6 dated 12/15/2023, revealed .resident was involved in an altercation with another resident .[Resident #6] .is pleasant and calm .no s/s [signs and symptoms] of distress . Review of the Nurse's Notes for Resident #6 dated 12/15/2023, revealed .house NP .was notified of resident-to-resident altercation .NP saw resident .new order .Tylenol [medication used to treat pain] 650 mg every 6 hours as needed .for pain . Review of the NP Notes for Resident #6 dated 12/15/2023, revealed .resident involved in a resident-to-resident altercation .small cut .bruise .above .left eye .painful to touch .Tylenol 325mg 2 tabs PO [by mouth] every 6 hours as needed . Review of the Physician's Orders for Resident #6 dated 12/15/2023, revealed .Acetaminophen [Tylenol] .325 mg .2 tabs [tablets] every 6 hours as needed .clean laceration with normal saline and pat dry, monitor s/s of infection . Review of a Skin Integrity Assessment for Resident #6 dated 12/15/2023, revealed .a 2.5 [centimeter (cm)] x [by] 0.1 [cm] x 0 laceration to the resident's left eyebrow with a small amount of blood .first aid applied . During an interview on 7/31/2024 at 9:21 AM, the NP stated Resident #6 was hit in the head with a water pitcher by Resident #283 on 12/15/2023. The NP assessed Resident #6 after the altercation, the resident received a small cut above the left eye with bruising and the resident was ordered Tylenol for pain. The NP confirmed Resident #6 was physically harmed by Resident #283 when he was hit in the head with a water pitcher. Review of the medical record revealed Resident #31 was admitted to the facility on [DATE] with diagnoses including Alzheimer's, Bipolar Disorder, Mood Disorder, Delusions, and Depression. Review of a comprehensive care plan for Resident #31 initiated 12/5/2022, revealed .Behavioral .at risk for behavior problems .screaming and yelling out .easily agitated and sometimes is difficult to re-direct .staff will . Anticipate care needs .provide them before the resident becomes overly stressed .allow him to express how he feels; praise him for any positive communication . Review of a quarterly MDS assessment dated [DATE], revealed Resident #31 scored a 00 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review revealed no behaviors were observed, and the resident received antipsychotic medications during the assessment period. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse's Note for Resident #31 dated 6/18/2024, revealed .Psych NP rounded today .New orders received .decrease Risperdal [medication used to treat Bipolar Disorder] to 0.25 mg at bedtime . Review of a comprehensive care plan for Resident #31 revised 6/27/2024, revealed the resident was involved in a resident-to-resident altercation. The interventions included .individualized signage on door to identify his room .Psychosocial Follow-up for 72 hours .Separate residents immediately . Review of the Nurse's Notes for Resident #31 dated 6/27/2024, revealed .Resident exhibited aggressive verbal and physical behaviors towards others .placed on [every] 15 minute checks with direct supervision . Psych NP advised to attempt psych placement for increased behaviors . Review of a facility investigation dated 6/27/2024, revealed a resident-to-resident altercation between Resident #31 and Resident #45 had occurred. Certified Nursing Assistant (CNA) I reported to the charge nurse Licensed Practical Nurse (LPN) E she heard loud noises from Resident #74's room. When CNA I entered the room, the CNA observed Resident #31 and Resident #74 arguing. Resident #31 made contact (hit) with Resident #74 using his walker. LPN E was called to the room by CNA I and witnessed CNA I separating the two residents. Resident #74 was observed to have a 1 cm skin tear to his left hand and a 0.5 cm skin tear to the right earlobe. Resident #31 had no injuries, and the residents were immediately separated. Resident #74's injuries were assessed and the wounds to the left hand and right earlobe were treated by LPN E. A psychological evaluation was performed on both residents with no psychological harm identified. Review of the Behavioral Progress Notes for Resident #31 dated 6/30/2024, revealed . memory impaired . judgement poor .insight poor .recent agitation, aggression .Cymbalta [medication used to treat Depression] 60 mg qd [daily] .Risperdal 0.5 mg q AM .0.25mg q hs [bedtime] Depakote 500 mg BID [twice daily] . Remeron 15mg q hs . Resident #31's Risperdal dosage was increased after the altercation (gradual dose reduction (GDR) was ordered on 6/18/2024). Review of the SSD Notes dated 7/1/2024, revealed .[Resident #31] was evaluated after the physical altercation .in no distress, had no concerns and there were no other incidents . Review of the medical record revealed Resident #74 was admitted to the facility on [DATE] with diagnoses including Dementia, Psychosis, Mood Disorder, and Alzheimer's. Review of a quarterly MDS assessment dated [DATE], revealed Resident #74 scored a 6 on the BIMS assessment which indicated the resident had severe cognitive impairment. Further review showed no behaviors were observed, and the resident received antipsychotic medications during the assessment period. Review of a comprehensive care plan for Resident #74 revised 6/27/2024, revealed .Mood State . Resident . is experiencing disturbed thought processes .secondary to .medical condition .staff will .1:1 visit with social services as needed . Allow resident to express their feelings .Consult with psychiatry/psychology as needed . Encourage and assist to activities .Notify MD with significant changes .resident was involved in a resident-to-resident altercation .Psychosocial Follow-up for 72 hours .Separate residents immediately . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the Nurse's Notes for Resident #74 dated 6/27/2024, revealed .No s/s of fear or distress noted .at baseline with emotional status. Resident denies any pain or discomfort . Review of the Physician's Orders for Resident #74 dated 6/27/2024, revealed .clean .skin tear to left hand and right ear lobe . Review of the Interdisciplinary Team (IDT) Notes for Resident #74 dated 6/28/2024, revealed, .IDT met and reviewed .Resident is often confused and has periods of agitation .reviewed and discussed recent interactions with others .no s/s of distress . Review of the SSD Notes for Resident #74 dated 7/1/2024, revealed . SSD followed up with resident . regarding the incident that occurred on Friday [6/27/2024] with .[Resident #31] .Resident stated that he is fine and no issues or concerns with the incident .stated .no other incidents have occurred with the .[Resident #31] . During an interview on 7/30/2024 at 9:00 AM, CNA I stated she witnessed the resident-to-resident altercation between Resident #31 and #74 on 6/27/2024. CNA I was walking down the hallway and heard what sounded like a .scuffle . coming from Resident #74's room. When the CNA entered the room Resident #31 had entered Resident #74's room, Resident #74 was exiting the bathroom, Resident #74 told Resident #31 to leave his room, and Resident #31 hit Resident #74 with his walker which resulted in an injury to the right ear lobe. CNA I immediately intervened and had Resident #31 put the walker down. When Resident #31 lowered the walker, Resident #74 hit Resident #31, and the walker caused a skin tear to Resident #74's left hand. LPN E was notified of the incident, and the LPN treated the injuries to Resident #74's left hand and right ear. CNA I removed Resident #31 from Resident #74's room, neither resident remembered the altercation when asked about it later in the shift, and no other behaviors were observed. CNA I also stated she had not observed Resident #31 in any altercations since the 6/27/2024 incident. During an interview on 7/30/2024 at 2:49 PM, LPN E stated she was working when the resident-to-resident altercation occurred between Resident #31 and Resident #74 on 6/27/2024. LPN E stated she was familiar with Resident #31 and Resident #74. The LPN was called to Resident #74's room by CNA I. CNA I informed the LPN Resident #31 had entered Resident #74's room. Resident #74 was coming out of the bathroom and saw Resident #31 in the room and told Resident #31 to leave. Resident #31 lifted his walker and hit Resident #74, scratching Resident #74's right earlobe before the CNA could stop him. Resident #74 attempted to punch Resident #31 to protect himself and hit the walker causing the skin tear to Resident #74's left hand. LPN E stated Resident #31 gets confused about what room is his and he entered Resident #74's room unintentionally. When the LPN entered Resident #74's room, CNA I had separated the residents. Both residents were assessed by LPN E, Resident #74 received a minor scratch on his right earlobe, there was a Scant amount . of blood. The earlobe was cleansed, and no further treatment was required. Resident #74 received a skin tear to the left hand , the hand was cleansed and required 2 steri-strips (wound closure tape). Resident #31 sustained no injuries and was taken back to his room immediately by CNA I and placed on 1:1 supervision for 72 hours. Both residents were monitored closely after the incident and 15 minutes after the altercation, neither resident could recall the incident. LPN E stated Resident #31 was usually easy to redirect when he had behaviors. Resident #31 had a GDR of Risperdal in June 2024 prior to the altercation .this might have caused the incident . LPN E stated Resident #31's Risperdal was increased back to the original dosage, and the resident had not had any further altercations or incidents. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 7/30/2024 at 3:11 PM, LPN F stated she was the Behavioral Health Nurse at the facility and was familiar with Resident #31. LPN F stated Resident #31 had a GDR of the Risperdal in June 2024, several days prior to the 6/27/2024 altercation between Resident #31 and Resident #74. LPN F did not witness the incident, but recalled Resident #74 received a minor injury to his earlobe. Resident #31's Risperdal was increased back to the original dosage, and the resident had not had any further altercations since the 6/27/2024 incident. During an interview on 7/31/2023 at 5:40 PM, the Interim Director of Nursing (IDON) stated she was not employed at the facility when the altercation took place between Residents #283 and #6. The IDON reviewed the medical record for Residents #283 and #6 and confirmed Resident #6 received an injury when Resident #283 hit the resident in the head with a water pitcher. Further interview revealed the IDON was not employed at the facility when the altercation took place between Residents #31 and #74. The IDON reviewed the medical record for Residents #31 and #74 and confirmed Resident #74 received an injury when Resident #31 hit the resident with the walker.