STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445429	A. Building B. Wing	04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ahc McKenzie	175 Hospital Drive MC Kenzie, TN 38201

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	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** Based on facility policy review, medical record review, observations, and interviews, the facility failed to report suspected abuse for 1 of 19 (Resident #4) sampled residents reviewed for abuse. The findings included: 1. Review of the facility policy titled, Abuse Prohibition Plan, revised on 11/2/2023, revealed .All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/ misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported .If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law .The administrator or the individual making the allegation immediately reports his or her suspicion to the following persons or agencies.The state licensing/certification agency responsible for surveying/licensing the facility.The local/state ombudsman.The resident's representative.Adult protective services (where state law provides jurisdiction in long-term care).Law enforcement officials.The resident's attending physician.The facility medical director.Immediately is defined.within two hours of an allegation involving abuse or result in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses including Cerebral Infraction (stroke), Anarthria (complete loss of ability to articulate speech), Hemiplegia (severe or complete paralysis of one side of the body) and Hemiparesis (partial weakness or inability to move one side of the body). Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 3 on the Brief Interview for Mental Status (BIM) assessment, which indicated she was severely cognitively impaired. She required total assistance with all Activities of Daily Living (ADLs). Review of the Care Plan revised on 3/25/2026, revealed Resident #4 had no updates related to bruising. During an observation and interview in Resident #4's room on 3/31/2026 at 2:35 PM, Licensed Practical Nurse (LPN) B did a skin assessment and observed bruising on resident's upper arm. LPN B was asked if she discovered bruising on a resident, what would she do. LPN B stated, .report to Director of Nursing, write a progress note regarding findings, I would look to see if resident had a recent fall that would explain bruising .do required skin assessment paperwork to document findings . During an interview on 3/31/2026 at 2:50 PM, the Administrator was asked if she was aware of an incident on 3/20/2026 involving Resident #4 and bruising to her upper right inner arm. The Administrator stated, No, I am unaware of any issues involving [Named Resident #4]. The Administrator was then told about the bruising to the Resident's arm that the sister noticed on her visit on 3/20/2026. The Administrator confirmed this was the first time she had heard of the incident and she would investigate the incident.^The Administrator stated, .I expect all forms of abuse to be reported immediately .^^ Review of the progress note dated 3/31/2026 at 5:31 PM, revealed the Director of Nursing (DON) documented .This nurse made aware per Administrator that resident's sister reported that she had observed bruising to upper ext. [extremity] around 3/20/2026. Upon (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment revealed 2 small areas mild discoloration areas to right upper arm on inner aspect . Review of the weekly comprehensive skin evaluation/assessments revealed there were no newly identified or existing wounds or skin integrity concerns documented on 3/4/2027, 3/11/2026, 3/18/2026 and 3/30/2026. No skin assessment was performed on 3/25/2026. During a phone interview on 3/31/2026 at 7:30 PM, the Treatment Nurse was asked if she worked on 3/20/2026. The Treatment Nurse stated Yes. The Treatment Nurse was asked if she recalled Resident #4's sister showing her bruising on the Resident's upper right inner arm. The Treatment Nurse stated .Yes, she had bruising on her upper right arm, it was faded yellow in color, not dark or purple in color, it was old, you could barely see it . The Treatment Nurse confirmed she had not reported the bruising to anyone. During an interview on 4/1/2026 at 10:10 AM, Certified Nursing Assistant (CNA) F stated, .the last shift I worked on 3/27/2026, we were giving report and [Named Resident #4]'s sister walked up .her sister was upset .and she said she had pictures of her [Resident #4's] arm with bruising. CNA F was asked if she told anybody about the sisters' concerns. CNA F stated, No. CNA F was asked if she should have reported it. CNA F stated, Yes. During an interview on 4/1/2026 at 10:20 AM, CNA E was asked about the incident on 3/27/2026 with Resident #4's sister. CNA E stated, .We were giving report, and [Named Resident #4]'s sister walked down the hall .she showed me the pictures of her upper right arm, in the pictures the bruising was very visible and looked bad . CNA E was asked if she reported what she saw in the pictures to anybody. CNA E stated, No. She was then asked if she should have reported it. CNA E stated, Yes. During an interview on 4/1/2026 at 12:10 PM, the DON was asked if she expected staff to notify her if they suspect abuse. The DON stated, Yes. The DON was asked if she should have been notified of the incident on 3/27/2026. The DON stated, Yes, abuse should always be reported. The facility's staff failed to report allegations of abuse related to unknown bruising found on Resident #4's arm on 3/20/2026 and 3/27/2026.