STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445454	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avondale Health and Rehabilitation Center, LLC	2031 Avondale Street Po Box 446 Humboldt, TN 38343

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 and interview, the facility failed to report an allegation of abuse for 1 of 3 (Resident #2) sampled residents reviewed for abuse. The findings include: 1. Review of the facility's policy titled, Abuse, Neglect and Exploitation, dated 12/2/2024, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Abuse means the willful infliction of.intimidation, or punishment with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse.Alleged violation is a situation or occurrence that is observed or reported by staff or resident.but has not yet been investigated.Mental Abuse includes but is not limited to humiliation, harassment, threats of punishment.The facility will have written procedures that include.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies within specified timeframes .Immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or.Not later than 24 hours if the events that cause the allegation do not involve abuse. 2. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses including Quadriplegia, Heart Failure, Dysphagia, Pressure Ulcer, Diabetes Mellitus, Gastrostomy, Anxiety, and Depression. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #2 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment, which indicated he was cognitively intact. Resident #2 had impairment on both sides and was dependent on staff to perform all Activities of Daily Living (ADLs). Review of the quarterly MDS assessment dated [DATE], revealed Resident #2 scored a 15 on the BIMS assessment, which indicated he was cognitively intact. Resident was dependent on staff to perform all ADLs. During an interview on 6/12/2026 at 11:52 AM, Resident #2 was asked regarding the incident that occurred on 3/6/2026 with Licensed Practical Nurse (LPN) B. Resident #2 stated, .She raised her fist at me, and the Administrator chose not believe me because there was no witness in the room to see it happen. Resident #2 was asked if he was fearful. Resident stated, I was at that particular time, she was standing near the curtain when I called her a [derogatory name], and that triggered her. She rushed towards me with her fist raised at me . During an interview on 6/12/2026 at 12:21 PM, Certified Nursing Assistant (CNA) C was asked if she recalled an incident with Resident #2 and LPN B. CNA C stated, I heard [LPN B] say he called her a [derogatory name].I went in the resident's room a few hours later and he was acting moody, I asked him what was wrong.He said [LPN B] bowed up like she was going to hit him. CNA C was asked if she reported what the resident had stated occurred. CNA C stated, I probably should have told the Administrator since it involved my charge nurse. During an interview on 6/12/2026 at 1:28PM, LPN B was asked to recall the incident that occurred on 3/6/2026 with Resident #2. LPN B stated, I went in [the resident's room] to administer his medications. I had doubled checked his meds [medications] to make sure I was administering what he was supposed to have. He was asking about an antibiotic that he thought I was supposed to administer. I informed him that I cannot administer anything that was not on his (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	electronic medical record. He became angry and very agitated. I assured him that I would check the computer again. After returning to his room, I told [Resident #2] it wasn't on there. He began to call me a stupid black [derogatory name].I told him he's not going to talk to me that way.I am not nobody's black [derogatory name]. During an interview on 6/12/2026 at 2:45 PM, the Director of Nursing (DON) was asked when she was made aware of the incident involving LPN B and Resident #2. The DON stated, I was made aware the next week because I had been off work when the incident occurred. The DON was asked who all should be notified when there is an allegation of abuse. The DON stated, Ensure to contact the Responsible Party and notify the Police, APS [Adult Protective Services], State Agencies, and Physician/Medical Director. During an interview on 6/12/2026 at 3:03 PM, the Administrator was asked when he was made aware of the incident with LPN B and Resident #2. The Administrator stated, I was immediately made aware of the incident after it happened. The Administrator was asked who informed him of the incident. The Administrator stated, I don't recall the staff member.They said there was a resident that was yelling and screaming at [LPN B]. The Administrator stated, An interview with [Resident #2] was performed to obtain his side of the story.[Resident #2] stated [LPN B] would not give him his antibiotics.I had [LPN B] pull up his medication administration record, and the medication was not due. I explained to [Resident #2] that it wasn't due and informed him that he cannot yell and cuss at the staff. [Resident #2] stated that she acted like she wanted to hit me. I immediately pulled her from the cart.I took her to my office asked her and asked about the allegation. The Administrator was asked what incidents should be reported. The Administrator stated, All allegations of Abuse. The Administrator was asked if this allegation was reported. The Administrator stated, No it wasn't . During an interview 6/12/2026 at 4:25 PM, the Assistant Director of Nursing (ADON) was asked if the physician and Responsible Party (RP) were notified of the allegation of Abuse. The ADON stated, I'm unsure. The ADON was asked who is responsible for notifying the RP and physician. The ADON stated, Someone in management. The ADON was asked who is responsible when the DON is on leave from the facility. The ADON stated, I did not notify the physician that day. ADON was asked should the RP and Physician be notified of allegations of abuse. The ADON stated, Yes, of course.