

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/04/2025
NAME OF PROVIDER OR SUPPLIER Shannondale of Maryville Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 803 Shannondale Way Maryville, TN 37803	
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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>Based on facility policy review, facility documentation review, and interview, the facility failed to maintain a grievance log for the required period of 3 years. The findings include: Review of the facility's policy titled, Grievances, dated 7/1/2009, revealed .Grievance Log will be kept for a period of three (3) years. The log shall contain evidence of the resolution and grievances . Review of the facility's Concern log revealed the facility had record of grievances from July 2024 - August 2025. There was no log available for grievances prior to July 2024. During an interview on 9/3/2025 at 11:44 AM, the Administrator confirmed no grievance log was available in the facility prior to July 2024. The facility changed administration and ownership in June 2024. The Administrator confirmed the grievance log was to be kept and available for review in the facility for a period of 3 years. During an interview on 9/3/2025 at 11:48 AM, the Case Manager stated she was the current grievance official at the facility. The Case Manager had been the grievance official since the facility changed ownership in June 2024. The Case Manager stated she was unaware where the grievance log was prior to July 2024. The Case Manager confirmed there was no grievance log available prior to July 2024 and that grievance logs were to be kept for a period of 3 years. The Case Manager stated she had reached out to the former grievance official who no longer worked at the facility who was unaware where the grievance logs were located.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 445472	Facility ID: 445472 If continuation sheet Page 1 of 5

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>(continued on next page)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, facility reported state intake information, medical record review, and interview, the facility failed to ensure allegations of abuse were reported to the appropriate authorities for 2 Residents (Residents #3 and #8) of 5 resident abuse investigations reviewed. The findings include: Review of the facility's undated policy titled, Abuse, Neglect, and Misappropriation of Residents Property, revealed .All alleged abuse and all substantiated incidents will be reported to the Bureau of Quality Assurance of Health Care Facilities and any other agencies as required . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Diverticulitis of Large Intestine, Dysphagia, Repeated Falls, and Dementia. Review of Resident #3's undated comprehensive care plan revealed . potential for impaired thought processes r/t [related to] dementia .Impaired thought processes .r/t cognitive loss .No male caregivers . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 3 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Resident #3 had moderately impaired vision with corrective lenses and exhibited no behavioral symptoms. The resident required a wheelchair for mobility and substantial/maximal assistance for toileting hygiene, shower/bathe self and personal hygiene. Review of the state agency facility reported incident intake information revealed the facility reported an allegation of sexual abuse for Resident #3 on 4/16/2024 by the former Director of Nursing (DON). The alleged incident occurred on 4/16/2024 at 2:25 PM. It was noted .It was noted, .Reporting out of an abundance of caution .[Resident #3] .had a Nurse approach her and she [Resident #3] stated 'Do Not let your daughter go to the bathroom alone.' She continued with 'There is 2 men .and they fingered me to death and I fell for the trap'. The resident also told the nurse. 'It was 2 old men' .investigation initiated Medical provider notified. Daughter notified . Continued review revealed .[Resident #3] .Resident was in the dining room, in her geri-chair watching television. Resident motion for nurse to approach her. The resident told the nurse 'Do not let your daughter go to the bathroom alone'. Nurse asked why? Resident stated, 'There is two men down there and they fingered me to death, I fell for the trap'. Nurse tried to comfort resident and notified social services of the situation. Social service notified the Director of Nursing (DON) .Investigation was initiated. Tearful .Physician notified .Social Service was notified .Resident exam with not injury noted .Conclusion .Not verified .No visitors or unknown people in the area. Resident was in sight of staff at all times .DX of dementia and when exam by staff RN [Registered Nurse], there was no harm or injury noted .Corrective Action .Have asked for no male caregivers for resident . During an observation and interview on 9/2/2025 at 3:07 PM, Resident #3 was lying in bed watching television. Resident #3 stated she had been at the facility for 2 weeks and the year was 3021. Resident #3 denied anyone hurting her or touching her inappropriately at the facility and stated . I'm bigger than everybody . During an interview on 9/3/2025 at 2:40 PM, the DON stated she was not employed by the facility at the time of Resident #3's allegation and did not participate in the investigation. The DON stated there was no documentation available in the facility related to the investigation of Resident #3's allegation of sexual abuse. The DON confirmed the only information she had related to the allegation of sexual abuse for Resident #3 was from the 5 day follow up report she was able to pull out of the facility reported incident computer system. The DON confirmed there was no other documentation available related to the allegation. The DON confirmed investigation documentation was to include what notifications were made. The DON confirmed she was unaware if law enforcement and Adult Protective Services (APS) were notified of Resident #3's sexual abuse allegation and stated there was no notification to law enforcement, Adult Protective Services (APS) .that I have located . Notifications to law enforcement and APS were to be documented and included in the facility investigation documentation. During a telephone interview on 9/4/2025 at 10:28 AM, the former DON stated she did not recall the allegation of sexual abuse for Resident #3. The former DON stated she would have been responsible for abuse investigations, and it would have included notifications to the family, physician, state agency, Adult Protective Services (APS) and police. The former DON stated all investigations were left in her desk drawer when she left the facility. During an interview on 9/3/2025 at 4:45 PM, the DON stated she was unaware if the former administration had notified law enforcement or Adult Protective Services (APS) of Resident #3's sexual abuse allegation. The DON stated she called the local police department on 9/3/2025 and there was no police report related to Resident #3 . The DON stated the facility had contacted APS on 9/3/2025 and left a message to determine if they had</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility policy review, medical record review, facility reported state intake information, the facility failed to maintain evidence that an allegation of abuse was thoroughly investigated for 2 residents (Residents #3 and #8) of 5 resident abuse investigations reviewed. The findings include: Review of the facility's undated policy titled, Abuse, Neglect, and Misappropriation of Residents Property, revealed .All unusual occurrences to residents are to be reported to the immediate supervisor and document on the accident/incident Report Record for follow-up, investigation and monitoring of events, occurrences and patterns which may constitute abuse or neglect .All alleged violations will be thoroughly investigated, and precautions will be taken to prevent further chance of abuse while the investigation is in process . Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Diverticulitis of Large Intestine, Dysphagia, Repeated Falls, and Dementia. Review of Resident #3's undated comprehensive care plan revealed .potential for impaired thought processes r/t [related to] dementia .Impaired thought processes .r/t cognitive loss .No male caregivers . Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 3 on the Brief Interview for Mental Status assessment which indicated the resident had severe cognitive impairment. Resident #3 had moderately impaired vision with corrective lenses and exhibited no behavioral symptoms. The resident required a wheelchair for mobility and substantial/maximal assistance for toileting hygiene, shower/bathe self and personal hygiene. Resident #3 was always incontinent of urine and bowel and received antidepressants, anticoagulants, and antibiotic medications during the 7 day look back period with indications noted. Review of the state agency facility reported incident intake information revealed the facility reported an allegation of sexual abuse for Resident #3 on 4/16/2024. It was noted, .Date of Occurrence: 4/16/2024 .Time: 2:25 pm .Patient .Age .89 .Sexual Abuse of Patient/Resident .Reporting out of an abundance of caution .[Resident #3] .had a Nurse approach her and she [Resident #3] stated 'Do Not let your daughter go to the bathroom alone.' She continued with 'There is 2 men .and they fingered me to death and I fell for the trap'. The resident also told the nurse. 'It was 2 old men' investigation initiated Medical provider notified. Daughter notified .Dx: [Diagnosis] unspecified Dementia, unspecified severity without Behaviors, other specified Anxiety disorders, Major Depressive disorder, HTN [Hypertension], constipation, unspecified Diverticulitis, UTI [Urinary Tract Infection], Fe [Iron] def [deficiency] anemia, nonrheumatic valve disorder, osteoporosis .Personal Hx [history] of TIA [Transient Ischemic Attack] .Bims [BIMS] 3 .Report Date: 4/16/2024 .Continued review revealed .[Resident #3] . Resident was in the dining room, in her geri-chair watching television. Resident motion for nurse to approach her. The resident told the nurse 'Do not let your daughter go to the bathroom alone'. Nurse asked why? Resident stated, 'There is two men down there and they fingered me to death, I fell for the trap'. Nurse tried to comfort resident and notified social services of the situation. Social service notified the Director of Nursing (DON) .Investigation was initiated. Tearful. assessment of the alleged victim with no medical treatment necessary. Physician notified .Social Service was notified .Resident exam with not injury noted. Remained in Dining Room in her Geri-Chair watching television. No witness to any incident .spoke with all staff working in the area .daughter .stated [Resident #3] had been raped by her uncle when she was between the ages of 6-8 .She didn't know any details. Daughter feels that her mom is just progressing in her dementia and that she is relieving things from her childhood. She requested that Psych [Psychitric] nurse practitioner see her. social worker arrange this as well as inform staff so we can comfort resident as needed .All staff reports that resident has been up in chair in the dining room .ate good lunch with no visitors this day .have been able to see her at all times. no distress was noted .Conclusion .Not verified .No visitors or unknown people in the area. Resident was in sight of staff at all times .DX of dementia and when exam by staff RN [Registered Nurse], there was no harm or injury noted .Corrective Action .Have asked for no male caregivers for resident . During an observation and interview on 9/2/2025 at 3:07 PM, Resident #3 was lying in bed watching television. Resident #3 stated she had been at the facility for 2 weeks and the year was 3021. Resident #3 denied anyone hurting her or touching her inappropriately at the facility and stated .I'm bigger than everybody . During an interview on 9/3/2025 at 11:53 AM, the Case Manager stated she had served as the Case Manager/social services since July 2024. The Case Manager did not participate in the investigation for Resident #3's abuse allegation, was unaware of the details, and unable to locate any social service documentation related to the allegation/investigation . Attempted telephone interview on 9/3/2025 at 3:21 PM</p>		