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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445476 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/08/2024 |
| NAME OF PROVIDER OR SUPPLIER Island Home Park Health and Rehab | | STREET ADDRESS, CITY, STATE, ZIP CODE 1758 Hillwood Drive Knoxville, TN 37920 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49568</p> <p>Based on facility policy review, medical record review, facility investigation review, and interviews, the facility failed to prevent physical abuse for 1 resident (Resident #1) of 8 residents reviewed for abuse.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Resident Rights, dated 2/2021, revealed .Federal and state laws guarantee certain basic rights to all residents of this facility .include the resident's right to .be free from abuse .</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation, Misappropriation Prevention Program, dated 10/2022, revealed .It is the policy of the facility to maintain an environment where residents are free from abuse .Abuse includes but is not limited to .physical .residents have the right to be free from abuse .Protect residents from abuse .by anyone including .facility staff .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] with diagnoses including Type 2 Diabetes Mellitus, Hypertension, and Generalized Muscle Weakness.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored a 15 on the Brief Interview of Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>(continued on next page)</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of the facility's investigation documentation for Resident #1 dated 7/11/2024 at 5:15 PM, revealed Certified Nursing Assistant (CNA) D answered Resident #1's call light, the resident stated her back was hurting. Resident #1 stated that she wanted to be put on her side and pillows placed between her legs. CNA D started to put the head of the bed down and Resident #1 started screaming at CNA D to stop. CNA D stopped and explained to Resident #1 she needed to lay flat to be able to turn the resident onto her side. Resident #1 raised herself up and put her finger in CNA D's face and screamed at the CNA. CNA D asked Resident #1 to stop yelling but the resident continued to scream and had her face in CNA D's face. CNA D then touched Resident #1's chin and asked the resident to stop. CNA D stated that she knew what she had done (touching the resident's chin) was wrong, immediately left the room and told Licensed Practical Nurse (LPN) B what had happened. LPN B instructed CNA D to wait in the conference room for further instructions. LPN B went immediately to Resident #1's room and assessed the resident's face. LPN B stated Resident #1 did not have any marks or bruising to face. Resident #1 thanked LPN B for checking her and stated she felt safe in the facility. LPN B assigned another CNA to Resident #1 and notified the Supervisor (LPN E) of what had happened. LPN E immediately went to assess Resident #1 and there were no red areas or bruising to the resident's face. LPN E immediately called the Director of Nursing (DON) and Administrator. CNA D was placed on suspension pending an investigation. CNA D was terminated on 7/12/2024 (1 day after the event) as the result of facility's findings during investigation.</p> <p>Review of the Progress Note for Resident #1 dated 7/11/2024 5:15 PM, revealed . CNA REPORTED TO THIS NURSE THAT SHE TOUCHED PTS [patient's] [Resident #1's] CHEEKS.THIS NURSE WENT TO ASSESS PT [patient] [Resident #1]. SKIN C/D/I. [clean, dry, intact] NO REDNESS OR BRUISING NOTED AT THIS TIME .NO S/S [signs or symptoms] OF DISTRESS OR DISCOMFORT NOTED. SUPERVISOR NOTIFIED. DON NOTIFIED. ADMINISTRATOR NOTIFIED .</p> <p>Review of the facility document titled, Admission Skin Assessment form, for Resident #1 dated 7/11/2024, revealed .no skin issues noted with skin .</p> <p>Review of the Local Police Department Initial Incident Report for Resident #1 dated 7/11/2024, revealed, . spoke with [Resident #1] who stated that [CNA D] had grabbed her chin .no visible injuries noted .</p> <p>Review of the Progress Note for Resident #1 dated 7/12/2024, revealed, .SS [Social Services] met with resident this morning in her room to follow up with event on 7/11 [7/11/2024] .calm throughout conversation with no signs or symptoms of distress noted .stated that she did not remember anything happening yesterday .confirmed that she feels safe in facility and denied any current needs. SS will continue to f/u (follow up) with resident for all SS needs .</p> <p>Review of the Progress Note for Resident #1 dated 7/13/2024, revealed, .lying in bed with eyes open .No s/s (signs and symptoms) of acute distress has been noted or reported .Mood and affect pleasant .</p> <p>Review of the Progress Note for Resident #1 dated 7/16/2024, revealed, .monitor mental status and provide psychotherapy as indicated .resident states she is very tired .she stated she is ok but did not elaborate on anything .did not mention the abuse allegation until asked if there was anything new that had happened . asked if she was feeling better and she said yes .</p> <p>(continued on next page)</p> | | |

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an observation and interview on 10/7/2024 at 1:05 PM, revealed Resident #1 lying on her left side in bed with the head of the bed elevated. Resident #1 stated she had been at the facility about 6 months, the staff were good to her, and she felt safe in the facility. Resident #1 further stated there was an incident with an associate (CNA D) in the past, the incident had been taken care of, and the resident did not want to talk about the incident anymore.</p> <p>During an interview on 10/7/2024 at 3:04 PM, LPN B stated on 7/11/2024 CNA D alerted LPN B that Resident #1 and CNA D had an altercation in Resident #1's room. CNA D told LPN B that Resident #1 asked to be rolled onto the back related to discomfort. CNA D told LPN B she proceeded to lower Resident #1's head of bed to reposition the resident. Resident #1 became belligerent and yelled at CNA D .don't lower me down, that's not how you do it . the resident continued to yell and point her finger at CNA D. CNA D stated she then squeezed Resident #1's cheeks and told the resident to not speak to her like that. CNA D immediately left Resident #1's room and reported what happened to LPN B. LPN B instructed CNA D not to go into any residents' rooms and to sit in conference room. LPN B went to Resident #1's room and asked the resident how she was doing. Resident #1 responded she was fine but wanted to report CNA D for squeezing her face. LPN B assessed Resident #1's face and there was no red areas or bruising noted. LPN B stated she repositioned Resident #1 while in the room. LPN B stated she asked Resident #1 again if she was okay and informed the resident that her safety was her biggest priority. Resident #1 stated she was fine and thanked LPN B for checking on her. LPN B notified the Supervisor (LPN E) of what had been reported.</p> <p>During an interview on 10/7/2024 at 3:18 PM, LPN E stated on 7/11/2024, LPN B reported to LPN E that CNA D had squeezed Resident #1's face. LPN E immediately assessed Resident #1's face and did not observe any red areas or bruising to the resident's face. LPN E further stated Resident #1 told LPN E that CNA D had squeezed her face. LPN E stated the DON and the Administrator was notified of the event. CNA D was placed on suspension pending and investigation and was sent home.</p> <p>During an interview on 10/8/2024 at 9:15 AM, Social Services Director (SSD) revealed she spoke with Resident #1 on 7/12/2024 and the resident stated she felt safe at the facility.</p> <p>During an observation, interview, and review of the facility investigation on 10/8/2024 at 12:20 PM, with the DON revealed on 7/11/2024 CNA D was providing care to Resident #1 and the resident became aggressive towards CNA D. CNA D touched Resident #1's face. CNA D immediately left the resident's room and told LPN B what happened. LPN B immediately assessed Resident #1's face for any injuries and did not observe red areas or bruising to the resident's face. The DON stated CNA D was asked to write a statement about the event. CNA D was placed on suspension pending an investigation, and the DON instructed CNA D to immediately leave the facility after the witness statement had been completed.</p> <p>During an interview on 10/8/2024 at 1:30 PM, The Executive Director confirmed physical abuse towards Resident #1 had taken place.</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27405</p> <p>Based on facility policy review, medical record review, facility investigation review, and interview, the facility failed to protect a resident's rights to be free from misappropriation and/or exploitation when money totaling \$400.00 was taken from 1 resident (Resident #3) of 4 sampled residents reviewed for misappropriation.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, reviewed on ,d+[DATE], revealed .It is the policy of the facility to maintain an environment where residents are free from abuse, neglect, exploitation and misappropriation of resident property .</p> <p>Review of the medical record revealed Resident #3 was admitted to the facility on [DATE] with diagnoses including Atrial Fibrillation, Type 2 Diabetes Mellitus, Malignant Neoplasm of Base of Tongue, and Adult Failure to Thrive. Continued review revealed the resident expired in the facility on [DATE] on hospice services.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #3 scored a 13 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident was cognitively intact.</p> <p>Review of the facility investigation documentation dated [DATE], revealed Resident #3 reported he was missing \$400.00 from his bedside table/nightstand. Resident #3 had stated he had last counted his money on [DATE]. He did not take his money with him on [DATE] when he left his room to go out to a doctor's appointment.</p> <p>Review of a police report dated [DATE], revealed .on [DATE] .received a call to a theft from building .[name of facility] .upon receiving call, the administrator .stated that a resident named .[Resident #3] .wanted to make a report regarding a suspected theft from his room of \$400.00 cash .the victim further stated that he had no idea who had taken the money from his room, and did not suspect anyone in particular .</p> <p>During an interview on [DATE] at 3:05 PM, Licensed Practical Nurse (LPN) B stated she was approached by LPN A who stated Resident #3 notified her of the \$400.00 missing. Continued interview with LPN B notified the Administrator who had instructed her to go and check the resident's room with his permission for the missing money. The LPN stated the money was not found.</p> <p>During an interview on [DATE] at 9:05 AM, LPN A confirmed she was the first-person Resident #3 had notified about the missing money. Continued interview confirmed both herself and LPN B searched the resident's room for the missing money and the money was not found.</p> <p>(continued on next page)</p> | | |

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| <p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>During an interview on [DATE] at 1:00 PM, the Administrator confirmed the facility substantiated the allegation of misappropriation for Resident #3. The Administrator stated the \$400.00 was reimbursed to Resident #3 by the facility. The Administrator further confirmed the facility could not determine who was responsible for the misappropriation of Resident #3's property.</p> |