STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445479	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Gray	791 Old Gray Station Road Gray, TN 37615

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38810 Based on facility policy review, medical record review, facility investigation review, and interviews the facility failed to maintain or enhance 1 resident's (Resident #4's) dignity and respect when 1 Certified Nursing Assistant (CNA) cursed in front of the resident while providing care of 11 residents observed for resident rights. The findings include: Review of the facility's policy titled, Resident Rights, dated 9/25/2023, revealed .Resident Rights .The resident has a right to a dignified existence . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE] with diagnoses including Dementia with Anxiety, Abnormal Involuntary Movements, Depressive Disorder, and History of Falling. Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #4 scored a 1 on the Brief Interview for Mental Status (BIMS) assessment which indicated the resident had severe cognitive impairment. Review of a comprehensive care plan for Resident #4 revised 6/11/2024, revealed .[Resident #4] is at risk for falls .receives psychotropic meds [medications] .he likes to put himself in the floor & [and] roll back and forth . Assist .as needed . Review of the facility document titled, Witness Interview Form, dated 6/12/2024, revealed .Title of person conducting the interview .[Director of Nursing (DON)] .Name of witness [Registered Nurse (RN) A] .Date of incident .6/12/24 [6/12/2024] .Time of incident .0005 [12:05 AM] .Resident [#4] .had a fall from .chair . [Certified Nursing Assistant (CNA) B] and I [RN A] attempted to get him [Resident #4] up .but he [Resident #4] was being combative .called the 200 unit and requested assistance .2 CNAS from that unit came to help us [CNA B and RN A] get him [Resident #4] up .[CNA B] started using curse words .I can't get .[Resident #4] out of this damn floor .My [CNA B] back is (explicit language) killing me .she [RN A] .sent CNA B to nurses station while the rest provided care for resident .she [RN A] called 200 unit charge nurse and they [RN A and Unit Charge Nurse C] .walked CNA B to the time clock .sent her home and notified ED [Executive Director] . (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
	445479	A. Building B. Wing	06/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Gray	791 Old Gray Station Road Gray, TN 37615

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility document titled, Witness Interview Form, dated 6/12/2024, revealed .Title of person conducting the interview .[Executive Director (ED)] .Name of witness .[CNA D] .Date of incident .6/12/24 . Time of incident .12:05 am .[Resident #4] [CNA D] and [CNA E] went back to .help .[CNA B] .get resident [Resident #4] off floor .As we [CNA D and CNA E] approached I [CNA D] heard [CNA B] say he [Resident #4] needs to stay .out of the floor he [Resident #4] is killing my damn back .[CNA E] went to get [Resident #4] out of the floor with [CNA B] .Once they [CNA E and CNA B] got him [Resident #4] in .chair .[CNA B] .said .can't pick him up no .damn more . Review of the facility document titled, Witness Interview Form, dated 6/12/2024, revealed .Went .to .help get resident [Resident #4] out of floor .he [Resident #4] was fighting .trying to get him up .she [CNA B] was . upset .he [Resident #4] was fighting when we [CNA B and CNA E] were getting him [Resident #4] up .I [CNA E] .recall her [CNA B] cussing but . I don't feel it was to . [Resident #4] . The witness statement was signed by CNA E and no other signature was observed on the form. Review of the facility document titled, Witness Interview Form, dated 6/12/2024, revealed .Title of person conducting the interview .Executive Director .Name of witness .[CNA B] .Date of incident .6/12/24 .Time of incident .approx [approximately] 12:00 am .were picking [Resident #4] off the floor and he [Resident #4] wouldn't stand up .was resisting .I [CNA B] am sure I [CNA B]said a few choice words but I [CNA B] can't remember and they [choice words] were not directed at the resident. I [CNA B] was just frustrated . The witness statement was conducted via telephone and signed by the ED. Review of a Psychiatric Evaluation dated 6/18/2024, revealed .Patient reports that staff has been treating him good .patient does not .remember curse words being used in his presence. No verbal altercation substantiated . During a telephone interview on 6/18/2024 at 10:01 AM, CNA E stated Resident #4 fell in the floor (unable to recall the exact date), staff were unable to assist the resident off the floor because the resident was fighting, and CNA E was asked to assist CNA B. It was hard to get .him [Resident #4] out of the floor .he was fighting and pushing against us [CNA E and CNA B] .I [CNA E] don't remember exactly what she [CNA B] said .she [CNA B] was frustrated because he [Resident #4] was fighting .pushing back against us [CNA E and CNA B] . She [CNA B] was cussing .I [CNA E] do not recall the exact words she [CNA B] used .it was not directed towards him [Resident #4] .[CNA B] was cussing but not at [Resident #4] . During a telephone interview on 6/18/2024 at 1:15 PM, CNA D stated Resident #4 fell in the floor, CNA D and CNA E went to assist CNA B with the resident. RN A attempted to assist CNA B but Resident #4 was fighting. As we [CNA D and CNA E] approached [CNA D] heard [CNA B] say he [Resident #4] needs to stay . out of the floor he [Resident #4] is killing my damn back .[CNA E] went to get [Resident #4] out of the floor with [CNA B] .Once they [CNA E and CNA B] got him [Resident #4] in .chair .[CNA B] .said .can't pick him up no .damn more . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Life Care Center of Gray		STREET ADDRESS, CITY, STATE, ZIP CODE 791 Old Gray Station Road Gray, TN 37615	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/18/2024 at 1:38 PM, the ED stated she was notified on 6/12/2024 of an allegation of possible verbal abuse. When the ED arrived at approximately 1:30 AM to the facility, she initiated an investigation. CNA D reported CNA B cursed in front of Resident #4 when staff was assisting the resident off the floor. Resident #4 was fighting against CNA B and CNA E, CNA B was frustrated and admitted to using curse words in front of the resident. The ED stated CNA D did not report CNA B cursed directly at Resident #4. CNA B was frustrated, used a poor choice of words, admitted she used a poor choice of words, but denied cursing directly at the resident. CNA B was employed at the facility for approximately 3 years with no complaints made against her from residents or co-workers regarding abusive behaviors. CNA B was terminated on 6/14/2024 for poor customer service related to cursing in front of Resident #4. During an interview on 6/18/2024 at 3:00 PM, the DON stated RN A was interviewed on 6/12/2024 regarding an alleged incident which occurred with Resident #4. RN A reported CNA B used curse words when the resident was assisted off the floor. RN A reported CNA B did not curse directly at the resident, the CNA cursed in front of the resident. During a telephone interview on 6/18/2024 at 3:25 PM, CNA B stated Resident #4 was seated in a broda chair [wheelchair used for positioning] in front of nurse's station. The resident fell in the floor and RN A and CNA B were unable to assist the resident back into the chair due to the resident was fighting. RN A contacted CNA D and CNA E from another unit to assist. CNA E and CNA B assisted Resident #4 into the chair, CNA D reported CNA B cursed the resident and CNA B was sent home. CNA B stated .I was probably cussing because my back was broke but I did not cuss at him [Resident #4] .I was wrong to cuss in front of him . CNA B became tearful and stated .I would never cuss my patients . During a telephone interview on 6/18/2024 at 3:48 PM, RN A stated she was the nurse on duty 6/12/2024 when Resident #4 fell on the floor from the chair. RN A and CNA B were unable to assist the resident off the floor, the resident was fighting. CNA D and CNA E arrived from another unit to assist with Resident #4. CNA B and CNA E attempted to assist the resident off the floor, the resident pushed against the CNAs, CNA B stated she could not get Resident #4 out of the damn floor .My back is (explicit language) killing me . RN A stated she worked with CNA B routinely, the CNA cursed in general [conversation] but the RN had not witnessed CNA B curse in front of any of the residents prior to 6/12/2024. During an interview on 6/20/2024 at 1:16 PM, the ED confirmed the facility failed to maintain dignity and respect for Resident #4 when CNA B cursed in front of the resident.