STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445481	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Place at Kingsport	100 Netherland Lane Kingsport, TN 37660

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** 37078 Based on facility policy review, medical record review, facility investigation review, and interview the facility failed to submit a 5 day follow up of the facility's investigation to the State Survey agency for 1 resident (Resident #1) of 4 residents reviewed. The findings include: Review of the facility's Policy titled, Resident Rights-Abuse and Crimes against, revised 6/16/2023 showed . all alleged violations .are reported .to the .state agency responsible for surveying/licensing the facility . continued review showed no procedure or process for submitting a 5 day follow up investigation, after the initial report to the State Survey agency. Review of the medical record showed Resident #1 was admitted to the facility on [DATE] with diagnoses including Muscle Weakness, Difficulty in Walking, and Cognitive Communication Deficit, the resident discharged to the hospital on 10/23/2023. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] showed Resident #1's Brief Interview of Mental Status (BIMS) score was 1 which indicated the resident had severe cognitive impairment. The resident required assistance of one or more staff members with activities of daily living (ADL's). Review of a current care plan showed Resident #1 had the .Potential for fall or injury r/t [related to] impaired cognition, poor safety awareness .Transfer with assist as needed .Ambulation with assist as needed . Bilateral soft mats to bedside .10/6 [10/6/2023] .Recommended 24-7 caregivers. 10/23 [10/23/2023] .Dycem [non-slip material] in wheelchair at all times .10/18 [10/18/2023] .may use broada chair [specialized wheelchair] when OOB [out of bed] .Send to ER [emergency room] as ordered. 10/23. 10/23/2023] . review showed multiple falls with new interventions in place with each fall. (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	Review of the facility's fall investigation showed on 10/23/2023 Resident #1 was up in his geriatric chair. Resident #1's spouse had came to the facility for a visit near dinner time and requested the resident be put in his recliner at approximately 5:40 PM. CNA A assisted the resident's wife with putting the resident in his recliner and Resident #1's spouse left sometime after dinner. At 8:28 PM, after having just walked by the residents room a few minutes earlier and seeing him in the recliner sleeping, Resident #1 was observed by CNA A lying on the floor on his right side next to his bed and the heater. A hematoma was noted on Resident #1's right forehead, the physician was notified, and orders were received to send the resident to the ER. The diagnosis from the hospital showed a Subarachnoid Hematoma (bleeding in the space between the brain and the tissue covering the brain). Continued review showed no documentation a 5 day follow up investigation had been submitted to the State Survey agency. Review of the State Survey agency INTAKE INFORMATION form showed the above incident was reported to the State Survey agency with .No 5 day follow up added . During an interview on 4/24/2024 at 11:00 AM, the Administrator stated .I checked and there was a 5 day follow up filled out, but it was never finalized so it wasn't turned in . confirming the facility failed to submit a 5 day follow up to the State Survey agency.